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Overview of the Prime Health Care Performance in Albania

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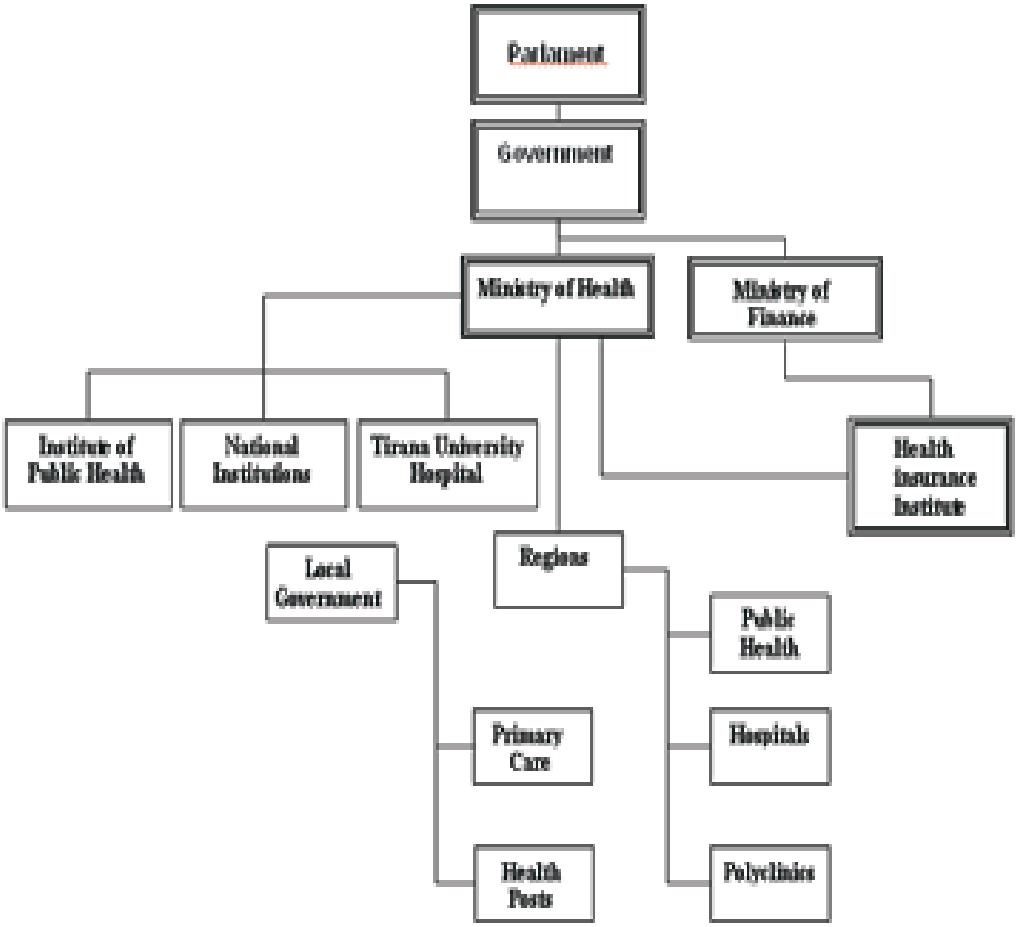
Abstract *Health is a very important aspect of human life, a fundamental human right. Even philosophically, people often refer to the concept of health as "a goal of existence." For this reason, healthcare should be considered as an important social goal of all individuals, all sectors and all institutions of a country. "Health should be an absolute priority order, as is an 'input' essential for economic development of society." After 1990 , the Albanian health faced a degradation and a greater disorganization. From a health system, which face challenges to recovery and treatment of diseases in epidemic form, it should be transformed into a new system that will be faced with new challenges related to the change of economic system, political opening country and its transformation into a country with market economy. No doubt that this radical change brought with it many challenges, but more importantly it was to find the key to realize the fundamental transformation of the health system itself and in the context of that primary. In this regard following the establishment of the Institute of Health Insurance, definitely the most important decision-making was to change the system of financing in the primary system by linking funding to service providers with their performance level. This paper introduces and analyses in general the prime health care focusing particularly on the health centers performance by analyzing different indicators. Greater difficulty in this regard was the construction of a scoring system, which can be measured in a realistic and objective performance level attained by the primary service providers. The paper is prepared by exploring the published literature and collecting data through secondary sources. Several data sources have been used to describe the PHC reform as well as the HC performance in the entire territory.*

Keywords: *prime health care, health center, performance, indicator.*

1. Health Care System

The health system in Albania is mainly public. The State is the major provider of health services, health promotion, prevention, diagnosis and treatments for the population of Albania. The private sector is still developing and covers most of the pharmaceutical and dental services as well as some clinics for specialized diagnosis, mainly being situated in Tirana. Ministry of Health takes the leading role in the public sector; it is the developer of policy and health strategies, for its regulation as well as the coordination of all participants both inside and outside the system. The diagnostic and curative health service is organized in three levels: primary health care, secondary hospital service and tertiary hospital service. Public health services and promotion are provided within the framework of the primary health care, supported and supervised from the Institute of Public Health. Other national institutions that offer their services are: the National Centre of Blood Transfusion, Centre for the Development and Well-growth of Children, Dental University Clinic, National Centre of Quality, Safety and Accreditation of Health Institutions and the Centre for the Continuous Education, the National Centre of Biomedical Engineering and the National Centre of Drug's control (MOH,2009).

Figure 1. *Organization of Health Care System in Albania.*



Source: *Ministry of Health, 2009.*

2. Prime Health Care

Primary Health Care (PHC) is currently used as a key reference for health population and development of health systems. World Health Organization (WHO) defines health as "welfare state of complete physical, psychological and social, not just absence of disease or of being impossible". This definition is applied in practice by offering a range of primary health care from health facilities (HC) in the respective communities.

The main mission of the Primary Health Care is to preserve the continuing improvement of health and to assure a living with the best health conditions for the people in accordance with the objectives "health for all". It represents the basic level of service where the person directly meets the health service for the first time and offers basic health care, near the people, where they live. Many elements of the public health practice are integrated primary health care services and gives priority to the hygiene-epidemiological situation, population's health demand, and the most emergent and cost effective programs in the fields of primary health care.

2.1. Health Centers a cell of Primary Health Care

Health Center (HC) is considered the basic unit that provides Primary Health Care .In most of the country, HC is an organization that includes several ambulances. HC staff (including ambulances) consists of managers, doctors, nurses, midwives and support staff. So health care services is not provided in a single building, but through a network of health care providers who work nearby communities. Each municipality has necessarily a HC and every village has an ambulance station and at least one nurse. On average, each HC serves a population of 8,000 people -10.000 (this figure varies significantly in urban and

rural areas), provided a report to doctor / patient about 1 to 2.500 and the ratio nurse / patient about 1 to 400(MoH,2010). In cities, some services, like guidance of the woman and child can be placed and operated outside the main HC, but are part of the center, as established in the same administrative division, serving the same population and having the same budget the administration . Services provided by HC respect the procedures and standards of the Ministry of Health to provide acceptable levels of quality, effectiveness and efficiency. HC Personnel formally cooperates with representatives of local government and community.

HC Mission - The mission of the HC is to provide community health services of high quality, comprehensive, continuous, integrated and accessible by all. HC staff responds to health needs of patients within the family medicine, mainly through health promotion, disease prevention and curative and palliative care.

HC Vision - HC vision is "*healthy people in healthy communities*." HC achieves this by applying the model of the MF in the community it covers

2.1.1 Values of HC

• *Dignity*: Treatment with respect and consideration of each patient, staff member, community members and understanding the differences between them;
• *Commitment*: Every member of staff is dedicated to the mission of the HC, to the community in general and in every patient particular;
• *Perfection*: HC reaches high level of excellence in fulfilling its mission by promote personal and professional integrity, continuously improvement of the quality and use of knowledge and modern technologies;
• *Integrity:* Staff uses the highest standards of ethics and professionalism and provides higher level of trust, through honesty in daily practice;
• *Collaboration:* HC staff members agree to work with each other, patients, government agencies and non-governmental organizations, donors and community.

2.1.2 Basic Principles of PHC Provided in HC-s are:

• Health care is a right, not privilege;
• PHC is based on implementation of results of the best research and social experience, medical and biomedical;
• PHC is based in the community and addresses the most prevalent health problems by provide preventive, curative, and health promotion;
• PHC encourages maximum involvement and participation of communities in planning, organization, implementation, control of the services offered by the HC;
• PHC is based on a combination of efforts of the health team consisting of doctors, nurses, midwives, dentists, public health workers and community workers;
• PHC requires integration in the chain of referent services, hospitals and access to specialist when needed higher level care.

2.1.3 Characteristics of the Services offered in HC

• Services reside in areas with the highest access for the population and are organized in such way as to be the first point of contact with national health care system;
• Services provided correspond with the main needs of the population (diagnosis, treatment, management and disease prevention and health promotion);
• Patients and families are followed by the same team of health care;
• Services offered are integrated and coordinated with higher levels of service, which provide specialized care as needed.

To exercise his specialty, the family physicians(FP) implements these competencies in three areas: **(i)** clinical tasks, **(ii)** communication with patients, **(iii)** management of HC.
Package includes the services covered by the Institute of Health Insurance (HII). This means that the package comprises a part of the PHC services provided by the HC. In addition to package delivery services, HC is also responsible for services such as surveillance activities for communicable diseases (case investigation, response to epidemics), vaccination in schools, vaccination-related activities outside the HC,

sanitation, etc. HC staff is responsible for reporting these services to the Public Health Directorate (PHD) in the region.

Family Medicine (FM) is a professional discipline which develops essential PHC. On this basis, the family Physicians (FP) should be able to:

1.Manage primary care;
2. Focus care to the individual;
3. Solve specific problems;
4. Offer inclusive care;
5. Provide integrated care;

3. Reformation of the Primary Health Care

3.1 Creation and Completion of Legal Framework

New ideas for development of the services offered by the HC in a higher quality and more directly in community service, were sanctioned in two decisions of the Council of Ministers (CMD Nr. 857 dt. 20/12/2006; CMD Nr.680 dt. 10/10/2007)and then followed by other legal acts and decisions of the HII . These actions had open the way to a profound reform in this service and were applied for the first time in the history of Albanian health care service. These decisions started and changed the mode of payment in all primary health care system by turning page and thus giving the opportunity to develop the system. These decisions were based on a pilot project approved by a Decision(CMD Nr. 811 Dt. 16.12. 2005) of 2005 in the district of Berat. After a great work in collaboration with USAID and after assessments by various stakeholders involved in this project (MoH, HII) and evaluating several other pilot projects, it was decided to be followed and applied throughout the territory Albania.

On December 2006, MoH introduced the Reform in Primary Health Care. The aim of the reform is the Improvement of Primary Health Care in a single source setting. It implements the Decision of Council of Ministers No. 857, date 20.12.2006 "For financing Primary Health Care Services" and it consists in :

- pooling of funds for Primary Health Care, near Health Insurance Institute,
- performance based payment,
- autonomy giving to Health Centers, it will be given a certain level of autonomy for objectives setting and in the management of their own resources according to services provided,
- services provided according to the package of services approved by MoH,
- setting in the same star/possibility of public and private sector for financing services provided by them, through the extension of services that are financed through the insurance scheme of Primary Health Care,
- regionalization of health care system, service planning in regional level to better meet population needs.

Implementation of the Reform started on January 2007. After January 2007, HII/RDHI has contracted with almost 420 Health Centre's all over the country or with 1625 General/Family Practitioners(GFP) and 6636 nurses who provide general services of health care. (MOH, 2009)

3.2 The Main Changes in PHC

Validation of the role of HCII as the only source of fundation to primary health care across the country and the extent of the scheme in this service. This means the unification of financial resources, hitherto fragmented primary care, in a single source.

Clear identification of the role of buyers and providers of this service, which means creating the conditions for the functioning of relationships between buyers and providers contract directly between them represented by the new HC as providers and health insurance scheme as single buyer represented by RDHI.

3.2.1 A New Way for HC Funding

- Fixed monthly payment (fixed) equal to 85% of the budget of HC. This payment for the period 2007-2010 in the history of the annual expenditure of HC and is given in equal monthly installments not later than the last day of previous month.HC uses this budget for:
- Wages and social insurance (doctors, nurses, support staff), o Expenses for goods and services - purchase of medicines and drugs in the use of HC, medical materials, energy, water, stationery,

printing and other costs.

- In terms of investment expenditures such as construction and reconstruction of health facilities, purchase medical equipment and apparatus, they remain an attribute of funding from the MoH.
- Monthly payment based on activity (PA) which is equal to 10% of the HC budget. This budget is given based on the HC number of visits to doctors per day, under a clearly defined standard in HC-RDHI bilateral contract. This transfer amount to the budget of every month from HC RDHI is made no later than the last day of the month.
- 3-month bonus payment (5% bonus). This charge consists of 5% of the budget of HC and considered as payment for quality of service provision in the coverage area of the HC. This amount is paid HC in accordance with the extent of implementation of quality indicators also stipulated in the contract and HC tranferohet no later than the last day of the first month of next quarter.
- The calculation of FP payment in our present system is made by the follow formula :

Payment of ***FP = p + n +g.p + v + b***.
P - Payment for prophylaxis N - payment for cargo (under coefficients)
G.P - payment for the location V - payments for seniority
B - pay for performance / bonus.

3.3. Drafting of the New Contract with HC Based on the New Legal Framework

Among the main points of this new contract in 2007 included:
• a new way of financing HC
• Methods of payment to staff physicians, nurses and assistant that the HC
• Preservation of the citizens' right for free choice of MPF
• Setting standards for PA
The standard of the average number of daily visits to the doctor would be:
- In the city (municipality) 16 visits a day / - In the village (commune) 13 visits per day.
• Establishment of 12 indicators of quality (5% Bonus)
• Ways to control medical and financial activity of HC from RDHI / HII.
• Developing a service package that HC should provide community covering.
• Setting the criteria for the Health Information System (HIS).
At the same time to meet better every aspect of the activity of HC exists and an individual contract(HII, 2007) signed between the leaders of the HC with GFP and secondary personnel that are clearly outlined the obligations and rights of both parties in relation to:
- Labor relations
- Respect the values of reimbursement for any physician.
- Ways of financial control by RDHI / HII

3.3.1. Binding of the New Contracts with HC

All these changed elements were reflected in the new contract which was signed in January 2007 between RDHI for HII and director (manager) of HC as an authority of the new HC. These contracts are clear timetable and are signed every early year. In this way for the first time in history of Albania, HII will not have an individual contract with HC GFP but as a structure already completed legally. Specifically HII made 408 new contracts with the management of HC that provide services with GFP and 5 contracts with health centers covered with specialist outpatient physicians (in Tirana) in total health institutions 413 that provide health care included in our scheme in the entire territory of the Republic. These contracts cover about GFP 1584 and 6660 plus 116 personnel SP(specialist) medium with a high cover of 2487 inhabitants / doctor in the country for the FP(HII, 2008)

Figure 2. *Distribution map of Albania RDHI(Regional Directorate of Health-care and Insurance)*

Source: *HII, 2009.*

Tab. 1. *Nr. of HC anf FP by RDHI in Albania*

Region	Nr.of HC	Nr. of Fam. Physicians
Berat	23	96
Diber	35	61
Durres	34	200
Elbasan	52	163
Fier	46	171
Gjirokaster	31	55
Sarande	13	33

Region	Nr. of HC	Nr. of Fam. physicians
Korce	39	143
Kukes	18	34
Lezhe	21	82
Tirane	35+5(Spec.)	341+116(Sp.)
Shkoder	37	107
Vlore	17	89
Tropoje	8	11

Source*: HII, 2009*

The responsible authorities for monitoring the contracts with HC are the subordinates structures of HII, designed from RDHI. The are in total 12 units, (by location of prefectures) and in their dependence are 2 RDHI(the saranda's and topoja's ones respectively depending on Vlora and Kukes) and 20 RHIA (Regional Healthcare and Insurance Authority).

3.4 The Basic Package of Services Provided from PHC

As an essential element of service delivery by the HC, the package of services is seen in terms of wider coverage of all essential services for the area in which HC exerts its activity. This element is part of the bilateral contract and controlled in terms of its ongoing implementation of HII structures. The importance of this lies in the fact that already every HC and her staff have very thing clear about what package of services should provide to their community and that this health center is funded by HII to

offer this package of services in the best manner possible.

3.4.1. Key Elements of This Package are:

• *Caring for adults* (for illnesses and symptoms prevalent in this category) that includes medical visit, diagnosis, treatment, prescribing, referral and tracking of ongoing.
• *pediatric care* (for diseases and symptoms most common in this category) that includes medical visit, diagnosis, treatment, prescribing, referral and tracking of ongoing.
• *Caring for children* in terms of monitoring of child growth and development and Immunization
• *Women's Health and Reproductive Health Care*. This category covers the most common services needed for women receiving services at the PHC.
• *Care for emergency cases*;
• *Health education*, information and promotion of patients health;
• *Prevention* of diseases, including immunizations;
• Management, administration, documentation and disclosure.
Home visits and treatment for people in the coverage area. (Appendix. Nr.1 CMD Nr. 857)
As mentioned earlier in this paper one of the new elements and most important of this reform is the way of financing the HC from HII. This new element in the health care system, require a clear explanation for its mode of application of the HC and it was one of the challenges that HII faced in the beginning of 2007. At this purpose served a series of trainings and meetings organized by various departments of the HII in this period (HII,2009). This process was conducted at all providers levels of primary health care services. Although there were also skeptical about the feasibility of applying this deep reform and particularly of the application of new methods of financing the growth of HC and their indicators (MoH, 2010), we can say that in pursuing these changes in the first years of reform resulted that HC staff welcomed the required changes and they adapted very well to the new methods.

4. The Basic Services in PHC

HC provides first aid for medical emergency, referral of patients (including transportation), and manages the situation in case of natural disasters (including the completion of patient reference documentation and reference)
Service purpose:
Provide effectively and on time, first aid for all cases of medical emergency, threatening the loss of life or exacerbate physical and psychological conditions of the person and to treat pain or morbidity as appropriate (individual conditions). Provide first aid by qualified health personnel for evaluation and emergency treatment of problems - contact by phone or person directly:
• Provision of care in HC in continued service (24 hours); HC that provide service 24 hours determined with agreement between the MoH and HII
• Provision of care in the HC with intermittent service (8 hours).
• Provision of care outside the HC

4.1 Health Care for Children

4.1.1 Description of Service

Health care for children (0 - 14 years) in the HC is provided with promotional services, prevention (evaluation of growth and development, immunizations, counseling, nutrition) and curative in accordance with relevant guidelines in force.

4.1.2 The Purpose of the Service

Reduction of morbidity and mortality associated with major causes of diseases of children (especially 0-5 years) and the promotion of healthy growth and development of children in family and community. The management of common childhood conditions. Tracking and resolving problems of nutrition during the neonatal period.

4.2 Health Care for Adults

4.2.1 Description of Service

Health care for adults (14 - 65 years) include management of common acute problems and chronic, a large part of which relates to environmental factors and lifestyle. HC provides early diagnosis and management of cases, and intervention at every stage of these conditions for prevention and promoting healthy behavior.

4.2.2 The Purpose of the Service

- To reduce the number of complications of acute conditions and ensuring integrated service for patients with HC chronic disease, respecting clinical guidelines and protocols in force.
- Management of common health problems.
- Chronic problems (diagnosis, treatment, prevention, referral of these conditions is consistent with clinical practice guidelines or protocols applicable).
- Providing assistance to victims of domestic violence (evaluation, treatment, referral and reporting).
- Preventive care and patient education while respecting gender differences

4.3 Health Care for Women and Reproductive Health

4.3.1 Description of Service

Integrated health care for women in the HC covers aspects preventative, promotional, curative and rehabilitative. Services in HC is perceived as general of physical, mental, social, welfare connected not only with diseases or disorders of the genital apparatus, but also with the functions and operation of a lifetime. Such services include: care before, during and after birth for mother and child, family planning , prevention and early diagnosis of breast cancer of cervical cancer, sexual health, care for victims of abuse, prevention and management of the infections of the reproductive system.

4.3.2 The Purpose of the Service

Offering quality services from HC staff for women (reproductive age, pregnancy, at birth / after birth, and menopause) and patients with sexual health problems (male and female). Service aims to reduce morbidity and maternal mortality and prenatal mortality, reducing unwanted pregnancies, reducing unsafe abortions and early pregnancies, reducing premature births and underweight, the provision of safe performance of abortion and control of other infections of the reproductive system.

4.4 Health Care for the Elderly

4.4.1 Description of Service.

PHC for elderly (over 65) provides service in accordance with their specific needs. "Friendly" HC with the elderly adjust their attitude and skills of personnel as well as its internal system, according to the needs of the elderly, promote awareness of these patients about problems and services offered in their support for an healthy active life .

4.4.2 The Purpose of the Service.

To reduce the number of complications of acute conditions and to increase the number of patients with chronic disease, who were provided full service in the HC, observing clinical guidelines and protocols.

5. Results of Reform in its First Year (2007)

As mentioned above, due to the implementation of legal changes in 2007, the Health Insurance Institute

had its focus on a new relationship with HC sanctioned in a new contract. Its core was a new way of measuring performance through building a comprehensive system of indicators.

In the end of 2007 we had the first results from service providers in terms of started reform. By 2006 this indicator despite the documentation was not important for doctors, for HC and for the whole service. There was not a required standard for this indicator so its significance was not known. Considering it as an important element of the HC activity, an element that shows how engaged and committed are the physicians in pursuing the residents in their charge, an element of rational use of working time and as an indicator which brings the stimulus as a result of gaining a big budget with the HC activity in general and for doctors and other staff in particular, at the end of 2007 will see a qualitative and quantitative indicator.

Tab. 2. *Implementation of the PHC indicators 2006- 2007*

Nr	RDHI	Nr of visits. Total	Average.Visi./day/Fam.Phys.			PVFT	Total	PVFT/. pop.	Value.aver. prescription./	Nr. of Rec.	Rec/ visits
			Municip.	Comm.	Region	*Total*	*Habitant*	(ne %)	Habitant.		(in %)
1	BERAT	162991	9.3	4.5	6.9	27578	229,767	12.0	49.1	15508	9.5
2	DIBER	80634	6.8	4	5.4	15611	224,202	7.0	43.5	12634	15.7
3	DURRES	173104	5.5	1.9	3.7	31552	434,139	7.3	43.6	27641	16.0
4	ELBASAN	159332	6.3	3.2	4.8	29064	418,679	6.9	40.7	29264	18.4
5	FIER	279431	9.4	4.4	6.9	44099	473,744	9.3	60.4	29331	10.5
6	GJIROKA.	64045	8.2	3.7	6.0	13080	146,780	8.9	33.5	5052	7.9
7	KORCE	266597	11.1	5.5	8.3	46874	343,189	13.7	52.5	35168	13.2
8	KUKES	42744	3.7	2.5	3.1	7707	120,943	6.4	56.6	4228	9.9
9	LEZHE	84002	6.3	3.4	4.9	17723	180,161	9.8	37.7	8264	9.8
10	SHKODER	162458	7.9	4.1	6.0	31979	296,845	10.8	62.4	18055	11.1
11	TIRANE	804848	12.4	7	9.7	125997	746,750	16.9	156.4	109131	13.6
12	VLORE	134409	7.8	3.3	5.6	28448	325,241	8.7	47.3	16794	12.5
	TOTAL	2,414,595	7.9	3.9	5.9	419,712	3,940,440	9.8	57.0	311,070	12.3

Source: *HII, 2007*

Tab. 3. *Implementation of performance and quality indicators 2009-2010*

Nr.		Vis/day/ physic.			%PVFT / Habitant			Nr. Tot	Nr. Total of Visits			Nr.	% rec.
	RDHI	City.	Village.	Region	City	Village	Region	PVFT	City	Village	Tot. Region	Rec.	/vis.
1	BERAT	11.2	5.9	8.6	23.4	15.0	19.2	44,207	163,436	82,778	246,214	25,039	10.2%
2	DIBER	10.1	6.7	8.4	16.9	13.2	15.0	28,734	53,249	80,361	133,610	13,041	9.8%
3	DURRES	6.6	3.1	4.9	13.7	7.4	10.5	39,189	197,526	98,408	295,934	43,625	14.7%
4	ELBASAN	7.4	4.4	5.9	12.6	8.3	10.5	42,534	167,575	107,824	275,399	50,906	18.5%
5	FIER	10.8	8.6	9.7	22.8	22.0	22.4	77,564	235,665	282,247	517,912	44,501	8.6%
6	GJIROKAS.	9.5	3.4	6.4	16.5	8.1	12.3	17,723	64,088	35,995	100,083	7,678	7.7%
7	KORCE	12.7	7.5	10.1	27.6	17.0	22.3	74,867	238,483	190,599	429,082	49,809	11.6%
8	KUKES	7.2	6.2	6.7	9.8	16.2	13.0	16,092	32,779	56,854	89,633	6,548	7.3%
9	LEZHE	8.2	5.2	6.7	20.3	10.3	15.3	27,880	80,567	64,800	145,367	15,034	10.3%
10	SHKODER	11.3	5.8	8.6	16.9	10.5	13.7	28,324	157,111	120,486	277,597	25,458	9.2%
11	TIRANE	12.8	10.6	11.7	28.0	21.6	24.8	201,601	987,246	267,183	1,254,429	146,850	11.7%
12	VLORE	9.6	4.6	7.1	16.6	8.3	12.5	35,276	185,706	60,465	246,171	19,561	7.9%
Total Repub.		9.8	6.0	7.9	18.8	13.2	15.9	633,991	2,563,431	1,448,000	4,011,431	448,050	11.2%

Source *:HII, 2010.*

Comparing the two tables above we clearly see that at the end of the first reform have significant changes in indicators of HC across the country. So for the first indicator (Average / visits / day / Family Physician) have the following reports:

• Nr. between. visits / day for FP in urban areas is 9.8 in 2010 compared to 7.9 in 2007

• Nr. between. visits / day for FP in rural areas is 6.0 in 2010 compared to 3.9 in 2007 Nr. between. The visits / day for FP to national level is 7.9 in 2010 → compared with 5.9 in 2007. In another way we can say that this indicator showed an increase of 33% in 2010 compared with 2007, but nevertheless is still far from the standard set in the contract of 16 visits in urban and 13 rural(HII, 2010).

5.1 Percentage of PVFT and Recommendations

Regarding the second indicator comparable to 2007 that is exactly the percentage of people that made a visit for the first time (PVFT) during a calendar year to the FP. This indicator is associated with attendance and choice of the doctor by individuals, respecting principles of constitutional and the Charter of Patients Rights to choice the family physician free.
For the performance of this indicator we can say that:

- Conduct PVFT's in 2010 → 15.9% compared with 9.8% in 2007 and expressing the increase in % we can say that in 2010 we see an increase of 62% compared to 2007 (relative index). This reflect growth of this indicator in urban areas and in rural areas. One other indicator is required in 2010 under the contract was the percentage reduction in the number of recommendations(Rec.) by the FP in terms of medical specialists. The performance of this indicator shows that:
- In 2010 this indicator was 10.8% compared to 2007 where the figures was 12.3% , we have an annual decrease of 1.5% but still not at the required standard.

In all of these indicators we can say that, despite the fact that not all indicators placed in the contract in 2007 due to lack of necessary information were measured and evaluated , many of them were evaluated and implemented. The results achieved in measurable indicators were very satisfactory and encouraging to all staff of HC.

In summary what has been achieved during the first year of reform which may be significant in consolidating the reform are:

- HC staff as an autonomous entity in their activity began to think, act and work as a partner authority structures
- Doctors and the entire staff of HC realize that by increasing the performance of their work will come improvement of service to the population that is contribution to the scheme and at the same time in accordance with the rates of performance indicators, so budgets and HC will significantly improve and doctors together with their staffs would be awarded better than the precedent year.
- HC Improvement of drug supply and other medication for their services in late 2009(HII,2009) was another sign that rose sharply to a better service and faster in the coverage area

5.2 Obstacles Encountered During the Reform Implementation

Some of the factors that influenced lack of measurement and evaluation of all indicators in 2007 were:

(i) *The election of the governing structures of HC.* This procedure began to be applied during the second quarter of 2007 and consequently it brought changes in management staff of HC. In front of them came different and difficulties tasks in the function of organization and operation of the center.

(ii) *Establishment and operation of boards* (two boards) was an influential factor in the maintenance and operation of the HC. There was a delay and uncertainty in the initial work of the board, which impacted negatively on the total performance of the objectives of the HC. Not in all regions during 2007 boards were a determining factor for the reform advance, in some cases due miss understanding of the reform as well as their competences.

(iii) *The large number of performance indicators* (12) and the requirement to meet all the indicators in order to obtain the bonus, was an influential factor in their implementation, in the absence of complete information, especially on the part of the legacy data by MOH

(iv) As in any other field, *experience* is very important factor for achieving a goal. Governance structure of the health centers showed no experience responding to the importance of the indicators and consequently the realization brought new difficulties.

(v) *Lack of* health managers, particularly inadequate education of managers HC

6. Reflections and Results of Reform in 2009-2010

Given the experience created in the first year of reform (2006-2007), especially in dynamic problems as well as tracking the results of indicators in 2009, nowadays is necessary to make changes. These changes consist in the number of indicators as well as their types. In this sense the focus of the HII structures at the end of 2010, during the preparation of new contracts , was:

6.1 The Importance of Establishing Indicators in Service of Providers and Beneficiaries

Awareness to understand the importance of establishing indicators from the perspective of service providers and beneficiaries. The value of indicators lies in the fact that:
• give us a clear vision of compliance and fulfillment of all the elements arising from the contract signed between the HC and RDHI.
• Show quality of HC services provided to the population, facing RDHI, which fund the health insurance scheme in the region
• Show professional values of every HC staff, within the current HC autonomy sanctioned by the legislation
• Provide sufficient information allowing the HC make comparisons with other HC in the region or in the whole country that have the same terms, or quasi same.
• And finally, last but not least, the implementation of these indicators apply a well known formula, already applied in the scheme of health insurance: *"One of the best reward for a better job"*

7. The Types and Characteristics of Performance Indicators

For us it is important that the service providers would understand better the characteristics of the set indicators and create a strong foundation for their implementation. Indicators must be simultaneously and objective likewise should met the condition of being SMART (specific, measurable, attainable, realistic, transparent).

7.1 Characteristics of Indicators and their Relation to the Services Provided.

a) How valid
• Serve to assess the real situation of the stage of HC
• It is possible to make comparisons
• Serve to analyze and to improve
• Cover the main services and the most significant activity of HC
b) Reliable
• Accuracy of data about the indicators
• Existence of the possibility of processing their exact
c) Regarding the structure and organization of the HC
• Indicators serves HC and their staff to have a more satisfactory financial return
• have direct connection with work made from the HC staff Physician / Nurse
• Are related to the budget
• Reconnect direct service to the patient
• Their importance is recognized by the staff of HC
d) The potential to measure
• They are understandable for all structures to manage the measurement and evaluation
• There are appropriate programs for measuring and evaluating their
• There are sufficient human resources to cover the workload
• There is a plan of action in case of unforeseen difficulties
e*) Objective*
• Has a degree in data fictitiousness
• Match the terrain HC (Mountain / Hilly) etc.
• It includes all categories of doctors who may have a HC

7.2 Payment Based on Activity (PA) Indicator

After negotiations with the Association of FP and the Order of Physicians the number of visits from 16 units in urban areas and 13 in rural areas decreased, making as well as a breakdown by category of physicians (MOH,2010).
Sharing daily visits to their doctor by category:
• Urban HC (municipality)
FP for all patients ages 12
FP to increase 12 "

FP for children 10 "
Specialists Physician(SP) 10 "
• HC in Rural Field / hilly area 9 "
• HC in Mountain / Deep Mountain area 6 "
This division would be more realistic and will respond to territorial and different specifications that have HC

8. Payment Based on Quality Indicators (5% Bonus)

Major changes were made to the number and types of quality indicators. These changes consisted in:
• Reduction of the number of indicators from 12 to 6 indicators.
• Changing the type of their activity to respond better to HC, the values of reimbursement, the epidemiological situation and reproductive health priorities of health policies in Albania. For the first time are set clearly defined formulas for calculating these indicators and a punctuation system depending on their importance.

T*ab. 4* *Types and tables of bonus indicators in 2010*

Nr.	Indicator	Points
1	Percentage of enrolled patients who were visited for the first time (PVFT) within one year by the FP	15
2	Prescription average cost per diagnose, per selected diagnose	20
3	Percentage of chronic patients, visited every month by FP	15
4	Percentage of the pregnant women who received the first visit within the first quarter of the pregnancy	15
5	Percentage of children 0-14 years, completely vaccinated	20
6	Percentage of HC staff participating in Continuing Medical Education.	15
	TOTAL	100

Source: *HII, 2010*

8.1 Percentage PVFT's Conducted Within the Calendar Year by Family Physicians

The purpose of establishing this indicator is that the HC and all its staff may be in closer contact with the population they cover. Increased contacts with residents registered with General Physicians in HC, enables a better understanding of the disease situation and the epidemiological area and as a result will realized capture, detection and treatment of diseases in the earliest stage. It will carry out likewise one of the main goals of PHC and health policies, which is seen as the gate opening at MF health system. Achievement of this objective will enable the realization of the first bonus indicator. HC in order to reach the maximum of 15 points for every 3-Month in the first quarter the amount should be 25% of PVFT for all patients enrolled in the HC / in the second quarter(II 3-M) should reach the figure of 12% / in third quarter(III, 3-M)should reached 8% and in fourth quarter (IV 3-M) should reach 15% of PVFT for all patients enrolled in the HC. In total corresponds to 60% which should also be the standard at the end of the year.

8.2 Prescription Average Cost per Diagnose, or per Selected Diagnose.

This indicator relates to the **average cost of the prescription for diagnosis,** and for several selected diagnoses based on region. In this case the diagnosis determined by each Regional Director is made known to all HC in the region following the closure of the 3-month period. At the end of each 3 month period, should be extracted in total 4 diagnoses (Dg) with higher refund amount, where in the first position should be placed the Diagnose with the highest value, the second is the Dg with little lower value than the first one, and so on the third and the fourth.
For each diagnosis extracted HC obtain 5 points, meeting the required 20 Points on this indicator.
• The importance of this indicator lies in the importance of treatment of patients with cost effectiveness.

• At the same time assessment of this indicator makes it possible to respect the values of reimbursement for physicians, HC and the region in general

To obtain 5 points for every Dg, the average reimbursement for a prescription with a given Dg. prescribed by doctors of a HC should not be higher than 5% of the average value of the prescription for the same diagnosis calculated in base of the region. Otherwise HC gets 0 points for Dg.

8.3 Percentage of Chronic Patients Visited Every Month by FP

This indicator is set to have a better monitoring of patients correctly as chronically recorded at each FP, which occupies the largest volume and the work of the physician and at the same time the major share in the reimbursement of medicines. By setting this indicator is aimed at:

• A better understanding to the situation of chronic and chronic morbidity from HC
• Planning of monthly visits by each FP for this category of patients and their continuous tracking

For this indicator which is equivalent to 15 points, HC is required to contact 95% of chronic patients each months. If this value is not achieved then number of accumulated points depends on the rate achieved and scores obtained.

8.4 Percentage of the Pregnant Women who Received the first Visit within the first Quarter of the Pregnancy

This is a new indicator introduced for the first time in the 2008 contract. This type of indicator is applied in many countries as a qualitative indicator and in the situation of our country takes a special importance. By this indicator we intend:

• Capturing of pregnancy among women in the 3-M's first lien which has a particular importance to the health of mother and child.
• Follow-up continued until the birth of pregnant women by applying rigorously all the decisions, guidelines and protocols on reproductive health in Albanian Republic
• Greater engagement of all HC staff: Physician / Nurse / Midwife

This indicator is measured by the number of pregnant women visiting for the first time in 3-month period of pregnancy on the total number of pregnant women visited for the first time during a 3-month period. If the HC reaches that quarter of all visits made for the first time is in 90% of pregnant women which are in their first 3-month period of pregnancy than it receives 15 points.

8.5 Percentage of Children 0-14 Years, Completely Vaccinated

By this indicator

• HC and all its staff may recognize the most rigorous way of vaccination situation for the category 0-14 years and greater commitment to the work of staff nurse / midwife.
• Rigorous implementation of all protocols and rules of the vaccination calendar in Republic of Albania
• Playing a greater role in the process of immunization by the FP, especially in rural areas. Making the visit by the doctor before vaccination.
• Administration of a highly accurate documentation at the HC on the issue of vaccination and accurate reporting of this activity at RDHI States and all other institutions associated with the implementation of this process.

Implementation and completion of the vaccination schedule at over 90% means 20 bonus points for the HC.

8.6 Percentage of HC staff Participating in Continuing Medical Education

This is the latest indicator of the table but not the last of its importance

• Continuing Medical Education (CME) is an indicator appreciate from all primary health care services in developing countries and for our country takes a special importance in order to build capacities in vocational and higher levels to enhance the quality of service to patients.
• Insurance Institute for achieving this indicator suggests and encourages all staff to create HC leadership facilities for the staff, to have all the possibilities to participate in all types of training that is recognized and regulated by the MOH, the HII and the Faculty of Medicine. Any training was required to be recorded and documented by the HC. So this report is accurate and verifiable.

Standard to gain 15 points by this indicator requires that 90% of HC staff have plan to perform a training

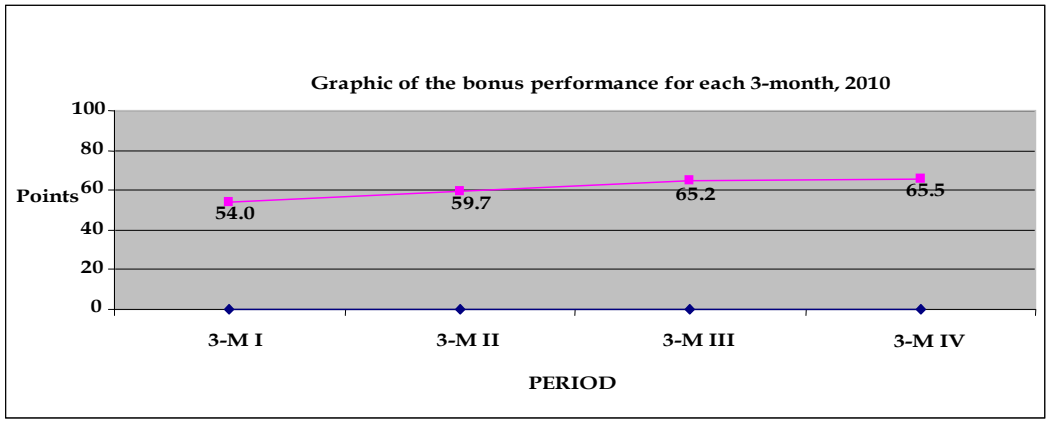
and any procedure must be documented at the HC. In total, if any HC catches 100 points at the end of a 3-month period, it receives in its budget by 5% as is enshrined in the contract. If this figure is not reached then the HC will benefit proportionally to the total level of points achieved

9. Implementation of the Indicators During 2009-2010

9.1 Implementation of Bonus Indicators (5%) During 2009-2010

In April, under all of the documented information was coming from the HC assessment of indicators for 3-month period of 2008 and this process continued throughout the 3 months period. As noted in the chart below realization of quality indicators from the first (I) 3-month period to IV it has increased what indicates a greater commitment to HC from one quarter to another to absorb the fund.

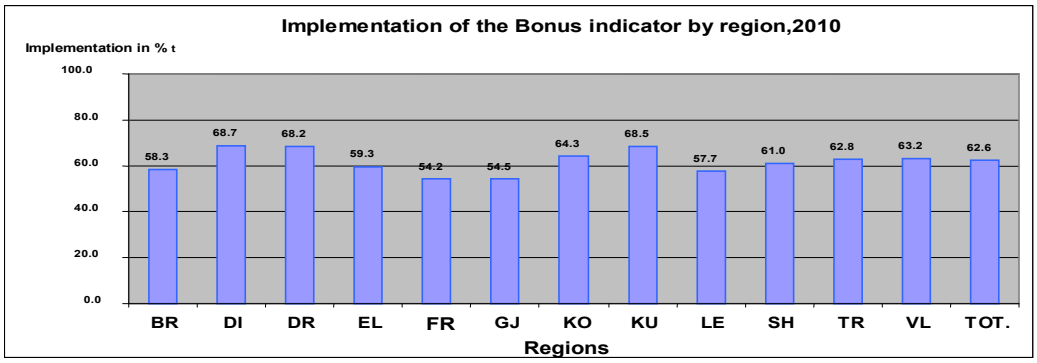
Fig. 3 *Implementation of the bonus indicators every 3 months period, 2010*



***Source**: MoH, 2010.*

9.2 The Annual Average Realization of Quality Indicators by 12 Regions and the Republic

Fig. 4. *Implementation of the bonus indicator by region and total for the republic, 2010 (%).*



Source: *MoH, 2010*

In total we can say that the bonus for 2010 was at 62.6% .The HCs in other words have gained on average an extra budget by 62.6 percent from the bonus fund.

The Implementation for the first time in our scheme of these quality indicators, although the difficulties of beginning, worked well and all contracted HII structures contributed to the realization of these indicators, The introduction of new concepts to improve the quality of service and their implementation on the ground, has been a major challenge in 2010.

9.3 The Percentage of Patients Visiting for the First Time in a Calendar Year.

The first indicator relates to the percentage of patients visiting for the first time in a calendar year by the

family doctor (PVFT).How does evolution of this indicator over the years?

Tab.5. *Nr of patients visited for the first time in HC, within a year.*

Year	Ne %	Patients visited for the first time in HC, within a year.
2006	9.8	419,712
2007	15.9	633,991
2008	17.3	696,147
2009	26.1	783,917 (364,215 more than 2006)
2010	28.1	827,358 (407,646 more than 2006)

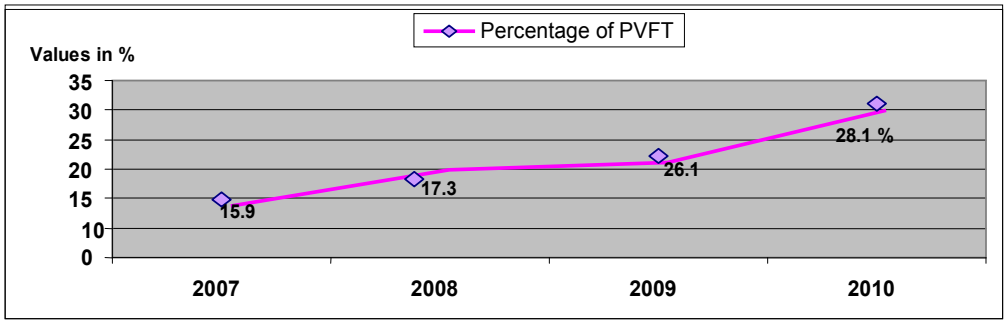
Source*: HII, 2010.*

In	2006	→	value	→	PVFT	9.8%	or	419.712	insured persons.
In	2007	→	value	→	PVFT	15.9%	or	633.991	insured persons.
In	2008	→	value	→	PVFT	17.3%	or	696.147	insured persons.
In	2009	→	value	→	PVFT	26.1%	or	783.917	insured persons.

If we compare with 2006, the year before the reform, we have 407,646 more patients who have received service at the HC.

Although many service providers worked so much and consequently the quality indicator was increased considerably in the last two years it still remains far from the standard required in the contract and from HII objectives

Fig. 5. *% of Patients visited for the first time in HC, within a year*



Source*: HII.2010 .*

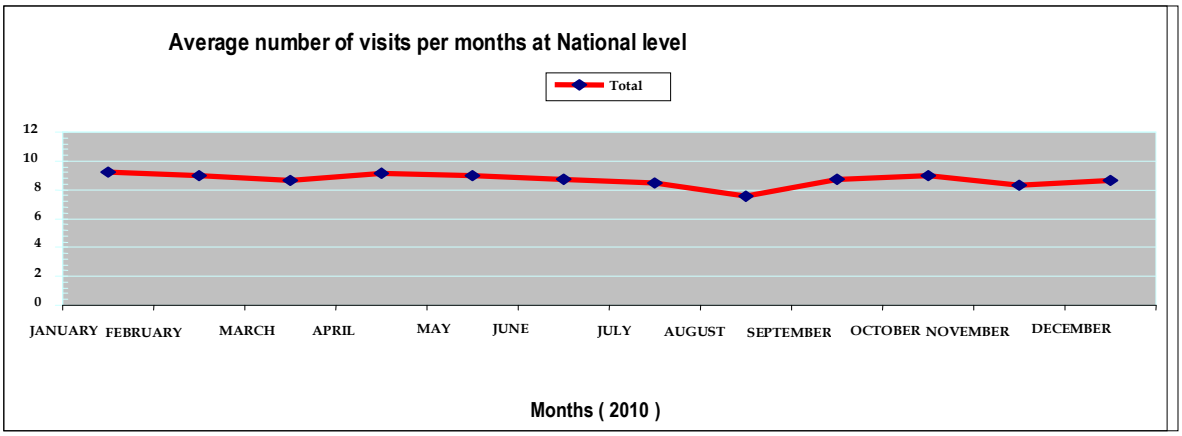
Factors that may affect the growth of this indicator would have been:

- Increase access and awareness of citizens on payment of health contributions and equipping them and the ensured categories with health booklet as the only document to obtain free visits. This point would serve to increase the value of this indicator but also the number of visits
- Respect of the reference correctly in all levels of health system
- Strengthening the role of FP as the first gate receiving health care
- Develop and implement national health programs for different categories of population control and prevention of various diseases.

9.4 The Number of Visits (PA) in 2010.

In relation to the number of visits as an indicator of the Activity of Physicians (PA) and staff of HC in general As mentioned above in 2010 were made changes compared to 2007. So from the end of 2009 the performance of this indicator is based on territorial divisions of the HC, the types of HC and according to categories of physicians in the structure of HC. Measurement and assessment of this indicator is made each month from RDHI and the table below shows the trend for each month.

Fig. 6 *Average number of daily visits per month in 2010*



Source: *HII, 2010*

Characteristic as noted in chart no. 4 is that in the months July-August we have a decrease in number of visits a phenomenon which occurs in the entire territory of the Republic and almost every year in this period.

9.4.1 The Number of Visits by Location

The following table describes the realization of no. of visits by location of HC for 2010, compared to the required standard

Table 6. *Implemetation of the nr of the visits by location of HC in 2010.*

Nr HC	REGION	CITTY	Mountain village	Others village	Tot. region
24	BERAT	11.6	5.2	8.1	9.6
34	DIBER	10.9	6	8.8	9.2
34	DURRES	7	1.5	5.5	5.7
52	ELBASAN	9.3	4.5	6.7	7.5
46	FIER	11.8	5.8	9.2	10.2
31	GJIROKASTER	8.3	4	4	6.1
39	KORCE	14.4	7.3	9.6	11.3
18	KUKES	8	5.7	8.5	7.3
21	LEZHE	7.9	5.3	5.5	6.7
35	TIRANE	14.2	10.5	10.4	12.1
36	SHKODER	10.3	4	6.2	7.7
17	VLORE	12.2	5.7	7.9	9.7
13	D. SARANDE	9.9	4.2	5.6	7.6
8	D. TROPOJA	14.9	8.3	8.3	11.5
408	Total vis/day/physician	10.8	5.6	7.4	8.7
	The Standarts	12	6	9	10
Implementation in %		90	93	82	88

Source*: MoH, 2010.*

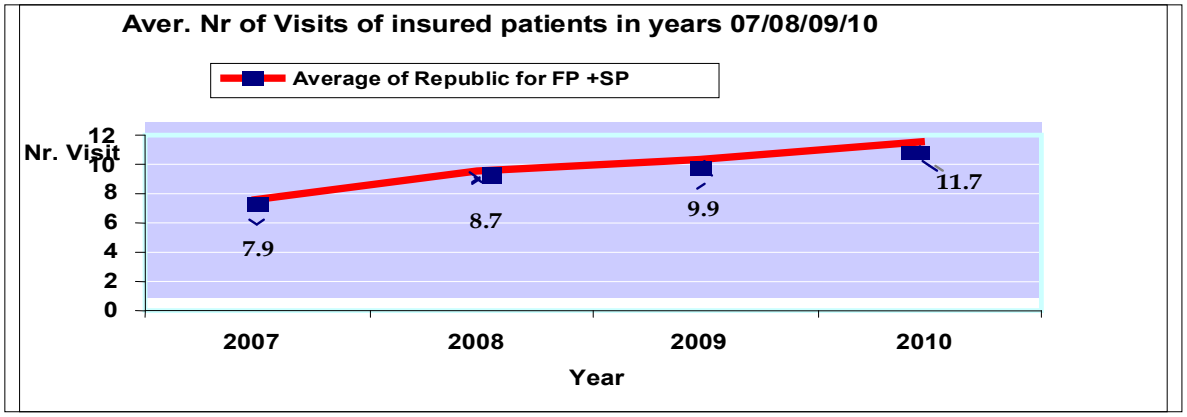
In this table we can see that the realization of the number of visits in urban areas is 90% compared with the standard and mountainous and hilly areas is carried out respectively at 93 and 82 percent. The total figure of the Republic which is averaging 8.7 visits per day for each doctor or 88% of the required standard is a satisfactory figure and that if we consider that it is only for the insured visits. This percentage translated into economic terms means that all HC in average ,in 2010 took in their budget 88% to 10% of payment activity. In some HC especially in urban areas, Berat, Vlora the benefit of 10% was realized at 100%.

Table 7. *Average number of visits per day in years.*

Area	2007	2008	2009	2010
Rural	3.9	6	6.7	6.9
Urban	7.9	9.8	10.8	12.9
Republ. Average	7.9	8.7	9.9	11.7

Source*: MoH, 2010.*

Fig. 7 *Average nr of visits of insured patients in years*



Source: *HII, 2010. Family physician(FP); Specialist physician(SP)*

The average number of visits in 2007 compared to 2006 is increased → 33%
The average number of visits in 2008 compared to 2007 is increased → 10%

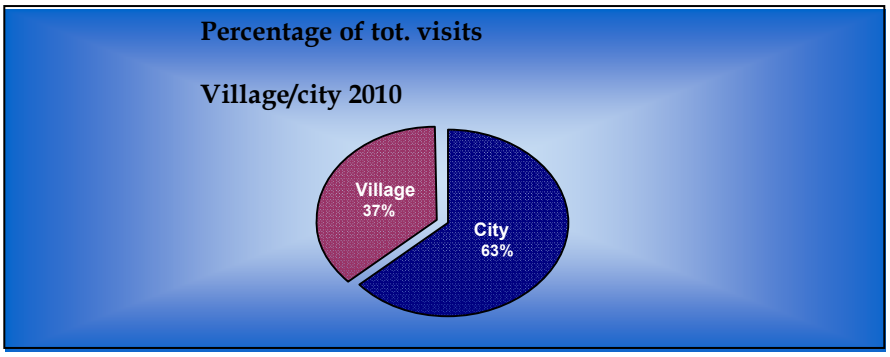
Or expressed differently this indicator (performance and quality of service) has increased from 13% in 2009 compared with 2008 and 67% compared with 2006.

By comparing 2008 with 2006 is increased by 47%. The increased average number of visits shows a greater attendance of HC from the population, a greater confidence to FP, which suits the policy of preventive and prophylactic (MoH, 2010).

9.4.2 Number of Visits in Town and Village

In the chart below provides a distribution of number of visits in town and village, reflecting also the accessibility of FP and HC versus population.

Fig. 8. *The percentage of visits in village / city during 2010.*



Source: *MoH, 2010.*

10. Comparison of Absorption of Funds. Performance Indicator.

10.1 Implementation of Indicators

The comparisions of the figures in the table demostrates the indicator implementation in 2010 higher in value compared with the precedent period. Therefore in 2010 HC had more budget benefits.

Table 8. *Indicator Implementation 2009-2010*

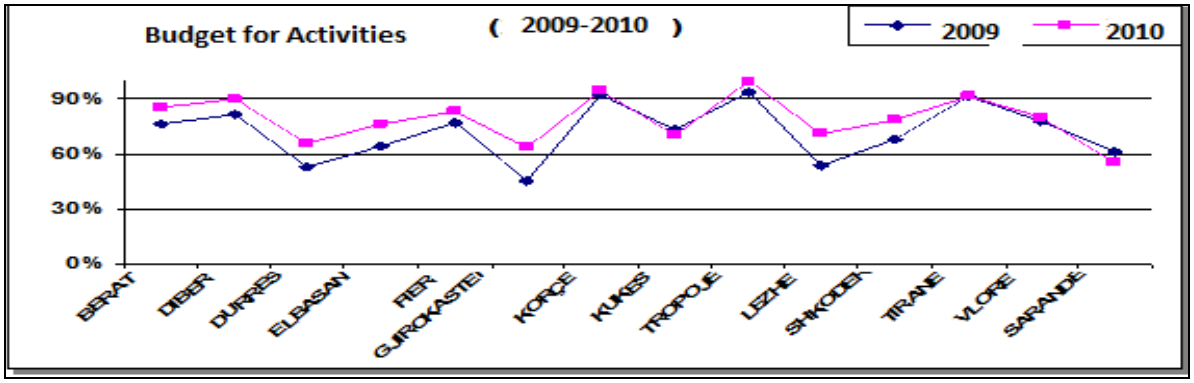
	2009	2010	Difference in %	Difference in Value (thausand)
Fix Budget (85%)	94.5 %	98.6 %	4.1 %	601,162 thousand
PA budget(10%)	71.3%	81.3 %	10 %	88,925 thousand
Bonus (5%)	42.6%	67.5 %	24.9 %	82,662 thousand

Source: *MoH, 2010.*

10.2 The Budget for HC Activities

In the following figure we can see the budget for HC activities dispalyed for two diferent periods. Its clear that the budget for acitivities in 2010 was higher than 2009, regardless the region.

Fig. 9. *Budget for HC activities*

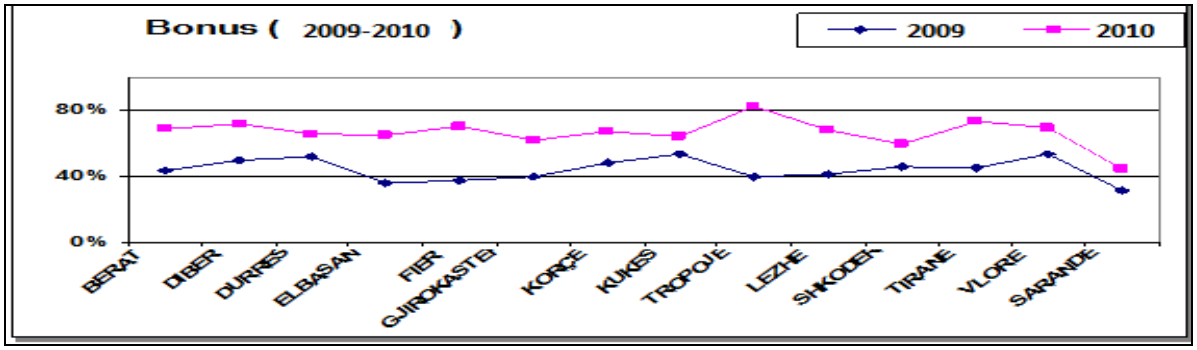


Source: *MoH, 2010*

10.3 Bonus Realization

As we can see from the fig.10 the realization of the bonus(5%) in the period of 2010 despite from the region is higher in values.

Fig. 10. *Bonus realization in different regions*



Source: *MoH,2010.*

11. Conclusions

The package of services and implementation of indicators built a new relationship between HII and HC, where the contracting process remains essential to health centers. Thus, health centers, referred to the new legal framework, have is a greater financial autonomy and administrative towards the use of funds and the secondary income. During this period every employee salaries is doubled and each employee of health centers benefit 14 salary per year (of which 2 salary bonus). Thanks to reforms, we can say with certainty that the number of insured persons registered, so people who have received the booklet compared with 2005, the number of persons who have received health card is almost doubled. However, the issue of identifying the full insured people, we think that will get the final solution after production and putting into use the health card for which is being worked. On the other hand HII itself, has made a better control on the allocation of funds by their performance on the health centers. So in 2009, increased absorption of funds from health centers for the performance indicator (number of visits) at 200% compared with the beginning of the reform (2007). This growing trend of interest of the population to use the health system through health insurance scheme has come as a result of measures taken by the Insurance Institute for improving the health service, in particular of the primary, which are:

(i) - financial reforms undertaken in primary health care in v.2007, which has financially motivated health personnel and thus increased quality of health care to patients

(ii) - better health care coverage across the territory of the country, from both quantitative and qualitative

(iii) - Strengthening the referral system at all levels of health care by strengthening the role of family physician as a "gateway entrance" to other levels of care.

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