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**PROJECT PERFORMANCE ASSESSMENT REPORT**

**REPUBLIC OF ALBANIA**

**HEALTH SYSTEM MODERNIZATION PROJECT  
(P082814)**

**and**

**SOCIAL SECTOR REFORM DEVELOPMENT POLICY LOAN  
(P116937)**

**June 24, 2014**

**IEG Public Sector Evaluation**  
*Independent Evaluation Group*

## Currency Equivalents (annual averages)

*Currency Unit = Albanian Lek (LEK)*

2005	US\$1.00	ALL 99.87
2006	US\$1.00	ALL 98.10
2007	US\$1.00	ALL 90.43
2008	US\$1.00	ALL 83.83
2009	US\$1.00	ALL 94.98
2010	US\$1.00	ALL 103.94
2011	US\$1.00	ALL 100.89
2012	US\$1.00	ALL 108.18

## Abbreviations and Acronyms

CME	Continuing Medical Education
CPG	Clinical Practice Guideline
CPS	Country Partnership Strategy
DPL	Development Policy Loan
ECA	Europe and Central Asia Region
ESW	Economic and Sector Work
EU	European Union
EUR	Euros
GDP	Gross Domestic Product
HII	Health Insurance Institute
HSMP	Health System Modernization Project
IBRD	International Bank for Reconstruction and Development
ICR	Implementation Completion Report
IDA	International Development Association
IPH	Institute of Public Health
IEG	Independent Evaluation Group
IEGPS	IEG Public Sector Evaluation
LSMS	Living Standards Measurement Survey
M&E	Monitoring and Evaluation
MIS	Management Information System
MoH	Ministry of Health
MoSW&Y	Ministry of Social Welfare and Youth
NCQSA	National Center for Quality, Safety and Accreditation of Health Care Institutions
NE	Ndihme Ekonomika Social Welfare Program
OOP	Out-of-pocket
OPEC	Organization of Petroleum Exporting Countries
PAD	Project Appraisal Document
PDO	Project Development Objective
PHC	Primary Health Care
PHRD	Population and Human Resource Development
PIU	Project Implementation Unit
PPAR	Project Performance Assessment Report
SAMP	Social Assistance Modernization Project
SDC	Swiss Development Cooperation
SDR	Special Drawing Rights
SIDA	Swedish International Development Agency

TF	Trust Fund
TTL	Task Team Leader
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children’s Fund
USAID	United States Agency for International Development
WHO	World Health Organization

## **Fiscal Year**

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This report was prepared by Denise Anne Vaillancourt, with input from Olinga Rafat, based on their assessment of the projects in Albania in November 2013. The report was peer reviewed by Bjorn Ekman and panel reviewed by Kristin Hallberg. Viktoriya Yevsyeyeva provided administrative support.



## Principal Ratings

### Health System Modernization Project (P082814)

	ICR*	ICR Review*	PPAR
Outcome	Moderately Satisfactory	Satisfactory	Moderately Unsatisfactory
Risk to Development Outcome	Moderate	Moderate	Significant
Bank Performance	Satisfactory	Moderately Satisfactory	Moderately Satisfactory
Borrower Performance	Moderately Satisfactory	Moderately Unsatisfactory	Moderately Unsatisfactory

\* The Implementation Completion Report (ICR) is a self-evaluation by the responsible Bank department. The ICR Review is an intermediate IEGWB product that seeks to independently verify the findings of the ICR.

### Social Sector Reform Development Policy Loan (P116937)

	ICR*	ICR Review*	PPAR
Outcome	Satisfactory	Unsatisfactory	Moderately Satisfactory
Risk to Development Outcome	Moderate	Negligible to Low	Moderate
Bank Performance	Satisfactory	Moderately Unsatisfactory	Moderately Satisfactory
Borrower Performance	Satisfactory	Moderately Unsatisfactory	Moderately Satisfactory

\* The Implementation Completion Report (ICR) is a self-evaluation by the responsible Bank department. The ICR Review is an intermediate IEGWB product that seeks to independently verify the findings of the ICR.

## Key Staff Responsible

### Health System Recovery and Development Project (P082814)

Project	Task Manager/Leader	Division Chief/ Sector Director	Country Director
Appraisal	Dominic Haazen	Armin Fidler	Orsalia Kalantzopoulos
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### Social Sector Reform Development Policy Loan (P116937)

Project	Task Manager/Leader	Division Chief/ Sector Director	Country Director
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To prepare a Project Performance Assessment Report (PPAR), IEG staff examine project files and other documents, visit the borrowing country to discuss the operation with the government, and other in-country stakeholders, and interview Bank staff and other donor agency staff both at headquarters and in local offices as appropriate.

Each PPAR is subject to internal IEG peer review, Panel review, and management approval. Once cleared internally, the PPAR is commented on by the responsible Bank department. The PPAR is also sent to the borrower for review. IEG incorporates both Bank and borrower comments as appropriate, and the borrowers' comments are attached to the document that is sent to the Bank's Board of Executive Directors. After an assessment report has been sent to the Board, it is disclosed to the public.

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**Outcome:** The extent to which the operation's major relevant objectives were achieved, or are expected to be achieved, efficiently. The rating has three dimensions: relevance, efficacy, and efficiency. *Relevance* includes relevance of objectives and relevance of design. Relevance of objectives is the extent to which the project's objectives are consistent with the country's current development priorities and with current Bank country and sectoral assistance strategies and corporate goals (expressed in Poverty Reduction Strategy Papers, Country Assistance Strategies, Sector Strategy Papers, Operational Policies). Relevance of design is the extent to which the project's design is consistent with the stated objectives. *Efficacy* is the extent to which the project's objectives were achieved, or are expected to be achieved, taking into account their relative importance. *Efficiency* is the extent to which the project achieved, or is expected to achieve, a return higher than the opportunity cost of capital and benefits at least cost compared to alternatives. The efficiency dimension generally is not applied to adjustment operations. *Possible ratings for Outcome:* Highly Satisfactory, Satisfactory, Moderately Satisfactory, Moderately Unsatisfactory, Unsatisfactory, Highly Unsatisfactory.

**Risk to Development Outcome:** The risk, at the time of evaluation, that development outcomes (or expected outcomes) will not be maintained (or realized). *Possible ratings for Risk to Development Outcome:* High, Significant, Moderate, Negligible to Low, Not Evaluable.

**Bank Performance:** The extent to which services provided by the Bank ensured quality at entry of the operation and supported effective implementation through appropriate supervision (including ensuring adequate transition arrangements for regular operation of supported activities after loan/credit closing, toward the achievement of development outcomes. The rating has two dimensions: quality at entry and quality of supervision. *Possible ratings for Bank Performance:* Highly Satisfactory, Satisfactory, Moderately Satisfactory, Moderately Unsatisfactory, Unsatisfactory, Highly Unsatisfactory.

**Borrower Performance:** The extent to which the borrower (including the government and implementing agency or agencies) ensured quality of preparation and implementation, and complied with covenants and agreements, toward the achievement of development outcomes. The rating has two dimensions: government performance and implementing agency(ies) performance. *Possible ratings for Borrower Performance:* Highly Satisfactory, Satisfactory, Moderately Satisfactory, Moderately Unsatisfactory, Unsatisfactory, Highly Unsatisfactory.



## Preface

This is the Project Performance Assessment Report (PPAR) for the Health System Modernization Project and the Social Sector Reform Development Policy Loan in the Republic of Albania.

A Credit (IDA-41540) for the Health System Modernization Project was approved on March 14, 2006 in the amount of SDR 10.7 million (US\$15.4 million equivalent). A Government of Japan (PHRD) grant (TF-55804) of US\$1.6 million equivalent provided cofinancing to the project, along with a planned Government counterpart of US\$2.1 million. The credit became effective on September 7, 2006 and closed on June 30, 2012, 21 months after the original closing date. The total cost at closing was US\$ 19.0 million equivalent. The credit amount disbursed was SDR 9.41 million, 88 percent of the original credit amount and 94 percent of the revised credit amount (SDR 10.0 million) after SDR 0.7 million was cancelled, due to mis-procurement.

The EUR 18.1 million (US\$25.0 million equivalent) Social Sector Reform Development Policy Loan (DPL) was approved by the World Bank on April 28, 2011, and became effective on August 25, 2011. This single tranche DPL closed as planned on April 30, 2012, and was fully disbursed.

This report is based on a review of project documents, the Implementation Completion and Results (ICR) Reports on each project, Aide-memoires and supervision reports and other relevant material, data and studies. A mission to Albania was undertaken by Denise Anne Vaillancourt, international consultant, and Olinga Rafat, local consultant, in November 2013, during which interviews were conducted with government officials and technical staff, service delivery personnel, civil society organizations, beneficiaries, relevant development partners and other involved persons. The team visited relevant offices and facilities in Tirana, Elbasan and Durrës regions, chosen in consultation with the Government and the Bank's team, and where over 60 percent of the population resides. The team also acquired additional insight from the Shkodra health district authorities, who presented their analysis of primary health care performance in that district at a November 20, 2013 Conference on Quality, held in Tirana. The beneficiary perspective was greatly enhanced by a recently published USAID study documenting consumers' assessment of the health care system. Interviews were also conducted in Washington with additional relevant staff. IEG gratefully acknowledges all those who made time for interviews and provided documents and information. And it expresses its gratitude to the Bank's office in Tirana for the logistical and administrative support provided to the mission, facilitating IEG's access to both former and current officials and staff. A list of persons met is provided in Annex C

This report serves an accountability purpose by evaluating the extent to which the operations achieved their intended outcomes. It also seeks to draw lessons to inform and guide future investments in the health and social protection sectors. This assessment also complements, respectively, the ICR Reports prepared by the Bank's operations teams with Borrower contributions and IEG's desk review (ICR Reviews) of these reports, by providing an independent, field-based assessment, some two years after the projects' closing.

Following standard IEG procedures, relevant officials of the Republic of Albania were invited to comment on the draft PPAR. These comments are presented in Annex I attached to this report.



## Summary

This report assesses the performance of two World Bank projects in Albania: the Health System Modernization Project (HSMP) (supported by an IDA credit of 10.7 million SDR, approved on March 14, 2006); and the Social Sector Reform Development Policy Loan (DPL) (supported by an IBRD Loan of EUR 18.1 million, approved on April 28, 2011).

At the outset of the HSMP, the health sector faced a number of challenges: the rapidly increasing burden of chronic disease on a weak health system; inequitable distribution of sector resources (physical, human and financial); low services quality and efficiency; high costs and lack of transparency of the drugs sector; high out-of-pocket expenditures, with little protection from impoverishment due to health expenses; and a fragmented financing system. Priorities agreed with Government centered on: (1) more efficient resource mobilization and allocation; (2) improvements in services quality and efficiency; and (3) improvements in sector management and stewardship.

At the outset of the Social Sector DPL, issues undermining the effectiveness of social assistance programs, included: the rapid increase in disability expenditures due to substantial increases in benefits costs and in the number of beneficiaries, squeezing out expenditures for the Ndhme Ekonomika (NE) Social Welfare Program targeted to the poor; and poor targeting and inefficient, non-transparent administration of the NE program, which caused some errors of inclusion (of the richer populations) and major errors of exclusion (of the poorest populations).

### **Health System Modernization Project (HSMP)**

The project objectives were to (a) improve the physical and financial access to, and use of, high quality primary health care (PHC) services; (b) to improve the Recipient's capacity to formulate and implement health policies and reforms in the health sector; and (c) to improve hospital governance and management. Special emphasis was put on the poor and under-serviced areas and on the reduction of unnecessary use of hospitals through improved PHC services. Three components supported the project objectives: (1) Strengthening Sector Stewardship, Financing and Purchasing; (2) Improving PHC Delivery; and (3) Strengthening Hospital Governance and Management.

The project became effective on September 7, 2006; and a mid-term review took place in December 2008. The objectives did not change, but two project restructuring exercises (May 2010; October 2011) caused activities to be added and dropped. The original closing date of September 30, 2010 was extended twice to June 30, 2012 to allow completion of hospital equipment procurement. The total actual cost was US\$19.0 million, almost exactly the appraisal estimate, but the allocation of expenditures across components changed. Implementation was very slow, due to: political strife related to the 2009 elections; significant turnover of Ministers (one per year on average), and of other leadership positions and technical staff; the filling of some positions with unqualified persons; and a lack of clarity of roles and responsibilities across key health institutions, whose roles were evolving.

The project's **outcome** rating is **Moderately Unsatisfactory**. *The project's objectives are highly relevant* to current country conditions, national strategy and priorities for the sector and the Bank's country and sector strategies. *The design relevance is modest*, overall. The results chain in the original design was largely supportive of the achievement of project objectives. However, some critical activities were excluded. The two project restructurings further weakened the results chain, adding a number of investments not directly supporting the project objectives (hospital equipment) and deleting others that were critical to these objectives (quality grant facility, health information system software).

*The objective to improve access, quality and use of PHC services and to decrease unnecessary use of hospitals was modestly achieved.* There are few reliable data and trends to document improved physical and financial access. Interviews, IEG's direct observations, a 2013 USAID study on consumers' perspectives and a 2014 World Bank public finance review all point to no substantial improvements. PHC data indicate that use of PHC services increased, almost achieving the target of 2.0 visits per capita per year. But secondary analysis of LSMS data reveal that between 2008 and 2012: (a) use of health services is lower among the poor; (b) use of outpatient care decreased for all five quintiles of per capita consumption; and (c) gaps between the rich and the poor's use of outpatient care have increased. Improvements to PHC service quality were not systematically tracked, but appear to be modest. Despite the population's general knowledge of how to use the referral system and incentives built into the insurance reimbursement mechanisms to this end, continued, unnecessary use of hospitals is documented by virtually all respondents, IEG's own observations and relevant studies. There are no data or trends to track progress on this front.

*The project substantially achieved the objective to improve capacity to formulate and implement health policies and reforms, especially with regard to new provider payment methods for PHC, based on capitation and bonuses.* A package of World Bank support, composed of analytic work, development policy lending and technical assistance and training supported under this project, has contributed to strengthened Ministry of Health (MoH) and Health Insurance Institute (HII) capacity in the formulation of well-conceived financing policy. Overall, implementation of health financing reform at the primary level was successful, particularly in the design and implementation of performance contracts for PHC. However, implementation of health financing reform at the hospital level fell short of expectations. The development of information systems for HII for prescription drug processing, patient registration/enrolment and service monitoring was only partially achieved; and the creation of a functional public health data warehouse in the Institute of Public Health was not achieved. Investments in strengthening MoH capacity for strategic sector management provided some important building blocks (a health strategy, M&E capacity building; annual performance reviews; and a national health accounts exercise). But they fell short of expectations, largely due to staff turnover and slow uptake of technical assistance. Important progress was made in strengthening the capacity of the National Center for Quality, Safety and Accreditation of Health Care Institutions (NCQSA) to strengthen its quality assurance and oversight functions. But there is a large unfinished agenda. The full appropriation and institutionalization of a quality culture throughout the

health system has not yet happened; and partnerships with civil society and consumers on quality have yet to be developed.

***The objective to improve hospital governance and management was modestly achieved.*** Project training appears to have had little impact on hospital management and financial management. Technical assistance supported the development of a model and regulatory framework, including by-laws and regulations, to support the move of MoH hospitals to the status of autonomous public entities. But the pilot testing of hospital autonomy in selected hospitals did not happen. Likewise, a hospital rationalization study was issued in 2008, but its pilot testing did not occur. ***Project efficiency is modest.*** Project resources were allocated to cost-effective, high impact interventions, well placed to convert resources into the desired outcomes. But restructuring reduced this efficiency. Implementation was inefficient, and not all objectives were achieved, even though the costs estimated at appraisal were fully incurred and the project took a full six years to implement versus the initial plan of four years.

***There is a marked difference between this PPAR's moderately unsatisfactory rating of the project's outcome and IEG's satisfactory rating of the project's outcome based on its 2013 desk review of the Region's Implementation Completion and Results Report.*** This PPAR downgraded IEG's initial ratings of: (i) design from substantial to modest based on weaknesses detected in the results chain, which became more evident in this in-depth analysis; (ii) efficacy of the first objective from substantial to modest based on the paucity and unreliability of relevant data and trends, and on the availability of new evidence since the ICR was produced; and (iii) efficiency from substantial to modest because the pre- and post-project economic analyses was based largely on expected benefits, whose achievements could not be verified.

**Risk to development outcome is rated significant.** Political and technical risks are moderate. Financial, institutional, governance and social risks are all significant.

**Overall Bank performance is Moderately Satisfactory.** ***Quality at Entry is Moderately Satisfactory.*** The project design was grounded in the 2006 health Policy Note, which has been noted by a wide range of informants to be of high technical quality and relevant to the challenges and issues the sector was facing. The implementation arrangements appropriately supported project management by a line Department within MoH. The design gave due attention to poverty dimensions of health sector reform. ***Quality of Supervision is Moderately Satisfactory.*** The Bank's supervision missions were sufficiently frequent and systematic. Supervision of fiduciary aspects was also thorough. The quality of the Bank's team has been widely acclaimed. Over and above work on the follow-on health operation, the Bank was very supportive and proactive in ensuring adequate transition arrangements when the new Government took power in 2013.

**Overall Borrower performance is Moderately Unsatisfactory.** ***Government performance is Moderately Unsatisfactory.*** Government provided 140 percent of its original counterpart commitment. But rapid turnover of Ministers, consequent rapid turnover of senior and well-qualified technical staff, and the appointment of unqualified staff to key positions for political reasons seriously undermined health sector capacity to

implement reforms, institutional memory and investments in capacity building. Project implementation was very slow. Tensions between MoH and HII affected project performance. ***Implementing Agency performance was Moderately Satisfactory.*** The project implementation unit within MoH carried out well most aspects of project management, including financial management, procurement, reporting and disbursements. Quarterly and annual reports on the project performance were submitted on time.

**Monitoring and Evaluation (M&E) was Modest.** The original M&E design had baselines, annual targets, data sources, frequency of collection and responsibilities all spelled out. Attempts to simplify indicators during the restructuring weakened the M&E design. M&E implementation fell short of expectations because of the lack of timely, reliable data and ill-defined indicators. Even though project M&E did not generate reliable data for decision-making, the performance data developed under the HII performance-based bonuses for PHC had a positive effect on the use of data for decision-making. But the use was limited to the financing of bonuses. There was no apparent use of data at district, regional or central levels to assess overall trends or to use them to enhance progress towards the project objectives.

### **Social Sector Reform Development Policy Loan (DPL)**

DPL objectives were to support policy changes to (i) improve the effectiveness of social safety nets, and (ii) enhance the efficiency and equity of health spending, in a fiscally sustainable environment. The DPL was also intended to enhance transparency and accountability by supporting policies to improve the administration of social assistance programs and promoting the use of systematic formulas to allocate resources in selected social programs and services.

The DPL was designed to support legislative reform in two policy areas. ***First, in support of social safety net effectiveness,*** the DPL was to support: (a) measures to improve targeting of the NE Social Assistance Program; (b) changes to limit the rapidly increasing share of the disability component of social assistance spending; (c) the introduction of bonuses for beneficiary families to enroll children in school and ensure daily attendance that could enhance the Program's effectiveness for reducing poverty in the long-run; and (d) amendment of NE legislation, mandating the creation of a national registry of all applicants and beneficiaries. ***Second, in support of health spending efficiency and equity,*** the DPL was to support: (a) the amendment of the health insurance legislation to grant health insurance coverage to all beneficiaries of the NE social assistance program and to establish the principle of an explicit package of benefits for beneficiaries, providing the basis for assessing the cost of benefits; (b) a more systematic approach to health financing, including provisions to maintain the payroll contribution for health insurance at 3.4 percent and to establish that transfers from the Treasury to HII on behalf of the uninsured would be based on the cost of providing a basic package of services; and (3) the development and co-signature (by HII and hospitals) of hospital performance contracts to support HII in its newly assigned role as sole purchaser of health services.

Upon satisfactory fulfillment of two effectiveness conditions (all prior actions taken; and the adequacy of the macroeconomic policy framework), the loan was declared effective on August 25, 2011, at which time the single tranche of US\$25 million was disbursed. The project was closed on April 30, 2012. Achievement of economic and fiscal targets fell short of expectations. Against a target for annual GDP growth rate of 6 percent by 2012, actual growth rates were 3.5 percent in 2010, 3.0 percent in 2011 and 0.8 percent (estimated) in 2012; and they are projected to average 2 percent per annum during the period 2012-2015. Macroeconomic targets set under the DPL were overly optimistic, especially in light of considerably more modest forecasts (of 3.2 percent for 2011 and 3.6 percent for 2012) made by the International Monetary Fund's Article IV Mission of 2010. The consequences of the financial crisis appear to have been apparent by mid-2011 when the loan was approved

**The project's outcome rating is Moderately Satisfactory. *The project's objectives are highly relevant*** to Albania's country conditions as well as to national and World Bank strategies. ***Project design is substantially relevant*** with a clear causal chain containing technical and strategic support to the objectives, and an appropriate choice of the DPL instrument, complementing (i) the technical support of the Bank's analytic work, technical assistance, and policy dialogue; and (ii) the health and social assistance investment operations designed to support reform implementation. The health policy area had some design shortcomings, however. ***The objective to support policy changes to improve the effectiveness of social safety nets was substantially achieved.***

Government's prior actions established a sound legislative framework for improving the effectiveness of social safety nets. Under the Social Assistance Modernization Project (SAMP) (approved on April 2012) implementation of social assistance reform is well underway, with strong Government commitment, after some initial delays caused by the elections and the installation of the new Government. While ambitious outcome indicators established under the DPL have not yet been achieved, strong Government commitment and good implementation progress provide strong indication that they are likely to be achieved. Evidence is strong that without the DPL the social assistance legislation may not have been passed at all. At the very least it would have experienced long delays and its quality would have suffered.

***The objective to support policy changes to enhance the efficiency and equity of health spending was modestly achieved. Improved health spending efficiency has not yet been achieved, and implementation support to this end has ceased with the closing of HSMP.*** Prior actions established a sound legislative framework for improving the efficiency of health spending, including: more predictable fiscal rules to finance health; transferred responsibility of financing hospitals to HII; and the signature of performance contracts between HII and the 42 hospitals in Albania. However, implementation of this new framework supported under the HSMP has been mixed, and outcomes have not been achieved; and they are not likely to be achieved without new support. Cost of services is not yet used as a basis for public transfers to HII because the definition and costing of services packages offered at different levels of the referral system is still ongoing. Ninety-five percent of hospital financing is still channeled through the Treasury and paid on the basis of expenditure receipts, not performance. HII is responsible for distributing only 5 percent of hospital budgets for 41 of the 42 hospitals. The only exception is the

Durres Regional Hospital, which is financed by HII on the basis of a performance contract and supported by USAID and others.

*Improved equity of health spending has not yet been achieved, and implementation support to this end has ceased with the closing of HSMP.* An additional prior action established a sound legislative framework for improving the equity of health spending: the passage of legislation to extend health insurance coverage to social assistance beneficiaries. However, this measure has not been implemented to date, largely due to fiscal concerns. Government's new vision of universal health care financed by the State may well succeed in extending health care coverage to these poor groups, but the feasibility and affordability of this vision needs to be assessed. In the meantime, the target of 100 percent coverage of NE recipients has not been achieved; and the outcome associated with reductions in health spending by the poor is difficult to document, and could not in any case be attributed to this legislation, which has not yet been implemented. Respondents were mixed in assessing the counterfactual of the health legislation in the absence of the DPL because (i) this legislation had been developed, refined and vetted with a range of actors and stakeholders within MoH and with higher echelons of Government, with technical assistance under the HSMP, and (ii) Government-wide commitment to its passage was already strong.

*There is a marked difference between this PPAR's moderately satisfactory rating of the project's outcome and IEG's unsatisfactory rating of the project's outcome based on its 2013 desk review of the Region's Implementation Completion and Results Report.* This PPAR upgraded IEG's initial ratings of: (i) design from modest to substantial because the underlying logic and the good choice of instrument became more evident during the course of the field work, especially for social assistance, and the choice of outcome indicators and targets, while overly ambitious, was more of an M&E design issue, not reason enough for a modest rating; and (ii) efficacy of the first (social assistance) objective from modest to substantial because of continued, notable progress in social assistance reform implementation and increased likelihood of achieving related outcome targets, albeit with delays. Both the 2013 desk review and this PPAR rate efficacy of the second (health) objective modest, but the 2013 exercise rates two sub-objectives, whereas the PPAR provides one rating for the health objective.

**Risk to Development Outcome is Moderate overall.** Financial risk is significant. But institutional and political risks are moderate.

**Bank Performance is Moderately Satisfactory, overall.** *Quality at entry is Moderately Satisfactory.* The quality of preparation and design is grounded in the high quality of the analytic work and sector dialogue of the Bank. The Bank's inputs and processes were intensive and supportive during the two-year preparation period. But the outcome targets were unrealistic. *Quality of supervision is Moderately Satisfactory.* The Bank was well focused on the development impact of the reforms. A moderate shortcoming was the quality in reporting on the project achievements, likely linked to the problem of overly ambitious outcome indicators established

**Borrower Performance is Moderately Satisfactory, overall.** *Government performance was Moderately Satisfactory.* The Ministry of Finance and the Prime



Minister were committed to the DPL and oversaw reform design and its passage in Parliament. Failure to take recommended measures to maintain fiscal stability under the DPL and to release the LSMS 2012 data in a timely fashion were two shortcomings, the latter undermining the monitoring and evaluation of results. ***Performance of the Implementing Agencies is Moderately Satisfactory.*** Both technical ministries were involved, informed and motivated to prepare the legislation. The Ministry of Social Welfare and Youth is engaged in its successful implementation under the SAMP, but MoH follow-through in the implementation of health financing reform was lacking.

**Monitoring and Evaluation was Modest.** The two sets of short-term indicators established for the DPL were too ambitious for the short timeframe and some were difficult to measure due to the infrequency of the LSMS exercises. Because the outcome indicators were more dependent upon the follow-on implementation assistance (and the continued unavailability of the LSMS 2012 results), there was very limited implementation of M&E during the project's short life.

## Lessons

This combined evaluation of the HSMP and the Social Sector DPL has revealed a number of cross-cutting lessons. Both projects: were grounded in analytic work and technical assistance; supported far-reaching reforms; sought to exploit synergies across various forms of Bank support and lending instruments; and faced a range of challenges inherent in reform implementation.

- The high quality of the Bank's analytic work and technical assistance is necessary but not sufficient for their effectiveness. Also important are the involvement and buy-in of the Government and other key stakeholders and the strategic packaging of this support with other Bank products and services.
- One-tranche DPLs can be transformative and support reform momentum if (i) they build on solid analytic work; (ii) they can effectively leverage critical policy change that may not gain sufficient traction through sector dialogue alone; and (iii) they are supported by continuity in the sector policy dialogue and lending after the DPL closes.
- Political economy is critical to factor into reform design and risk management. Neglect of some aspects of political economy is likely to have undermined prospects for the full and successful implementation of health reforms under the HSMP.
- The sequencing of reforms under the Social Assistance DPL and its follow-on implementation support is likely to have mitigated potential implementation setbacks associated with political feasibility, capacity and fiscal constraints.
- The design and implementation of pilots to test and fine-tune reforms and the establishment of well-functioning management information systems and M&E systems are critical to health and social assistance reform, as they can accommodate

learning, provide evidence of the feasibility and benefits of such reform and garner political support.

Caroline Heider  
Director-General  
Evaluation

# 1. Background and Context

## General Background.<sup>1</sup>

1.1 Albania has been a development success story in many respects. Over the past two decades the country has made enormous strides in establishing a credible multi-party democracy and market economy and it is rapidly re-integrating into the international and European communities. In addition, from the late 1990s and well into the new millennium, Albania was one of the fastest growing countries in Europe, enjoying average annual real growth rate of 6 percent, accompanied by a rapid reduction in poverty. Between 2002 and 2008 poverty fell by half (to about 12.4 percent), with extreme poverty affecting under 2 percent of the population. In mid-2008 Albania graduated from IDA. With the onset of the global financial and economic crisis Albania's growth rate was significantly reduced. Nevertheless, it is one of very few countries in Europe, which was able to maintain positive growth rates and financial stability since 2009 in spite of the economic downturn. Albania's prospects for continued growth depend upon: (i) early resumption of fiscal consolidation and strengthened public expenditure management; (ii) regulatory and institutional reforms to boost competitiveness and investment; (iii) improvements in education levels and skills to meet the demand from business; (iv) reduction of infrastructure deficits in a fiscally sustainable way; and (v) improvements in the effectiveness of social protection systems and key health services to avert new vulnerability risks that could arise as a result of the slow recovery. Reducing its vulnerability to climate change will also be critical.

1.2 Albania's political environment had been marked by tense relations between the opposition and the coalition Government, following the Parliamentary elections held in June 2009. The Socialist Party, which received about one percentage point less of the vote than the Democratic Party, had refused to take its seats in Parliament, demanding a partial recount, and staged a 19-day hunger strike in May 2010. Shared aspirations of achieving EU membership and mid-2010 pressure from the European parliament facilitated a resumption of the opposition's participation in Parliament. The Socialist Party won a landslide victory in the June 2013 general elections; and in September 2013 Socialist Leader Edi Rama became Prime Minister.

1.3 Albania's development priorities over the past six years have been guided by its National Strategy for Development and Integration (2007-2013) (Box 1.1.). A new strategy prepared by the former Government, with the participation of all parties, and slightly revised by the current Government demonstrates well that the prospect of EU membership continues to be pivotal in easing political tensions between the parties and in consolidating gains and further strengthening Albania's political, economic and social prospects.

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<sup>1</sup> Source: Country Partnership Strategy for Albania for the Period FY11-FY14, June 16, 2010.

### **Box 1.1. Albania's National Strategy for Development and Integration 2007-2013**

In 2007 Albania approved the National Strategy for Development and Integration for 2007-2013, which was developed through a participatory process, involving stakeholders throughout the country. The NSDI aimed to (i) integrate the country into the EU and NATO; (ii) develop and consolidate the democratic state, notably through electoral, judicial and property rights reform; and (iii) achieve rapid, balanced and sustainable economic, human and social development. The NSDI established target growth rates of 6-7 percent and aimed to reduce the poverty headcount to below 10 percent by 2013. It states that macroeconomic stability is to be supported by fiscal consolidation and reduction of debt. Infrastructure investments concentrated on roads and transport, energy, and water supply and sanitation. In the social services, the Government aimed to increase secondary education enrolment to 76 percent, introduce a basic package of covered health benefits, strengthen the coverage of the social assistance, and reform the public pension system. Following the 2009 Parliamentary elections, the Government reiterated the focus on the water sector (including water supply and sanitation, as well as irrigation for improved agricultural productivity) and the health sector, where resources would be concentrated in the next 2-4 years.

*Source:* Country Partnership Strategy for Albania for the Period FY11-FY14, June 16, 2010.

## **Social Assistance**

1.4 **Issues and Challenges.** A World Bank Social Assistance Policy Note prepared in 2010 found that, at 1.6 percent of GDP, total spending on social assistance in Albania was comparable to the regional average for Europe and Central Asia (ECA). Two main social assistance schemes accounted for the majority of this spending: (1) the Ndhime Ekonomika (NE) program, which is the main poverty-targeted social assistance benefit, and (2) disability assistance benefits. The relative balance in spending on these two programs had shifted significantly, however. Between 2000 and 2008, disability benefits increased from 0.4 percent to 0.9 percent of GDP, arising both from an increase in certified beneficiaries and from an increase in the size of the benefits. Disability legislation was found to be scattered, medical eligibility criteria outdated, and the system for assessing and certifying disability cases deficient and open to conflicts of interest. Growth in disability assistance benefits had been accompanied by a contraction in spending on the poverty-targeted NE program, which had fallen from 0.8 percent to 0.3 percent of GDP during the same timeframe.

1.5 The targeting accuracy of the NE program was found to be respectable in terms of relatively low leakages to the non-poor<sup>2</sup> and about average for countries in the ECA region. But there were issues with coverage, benefit adequacy and design features that undermined program equity, efficiency and transparency. Coverage of the poor was low, due to fiscal constraints (exacerbated by ballooning expenditures on disability benefits) and to a high degree of errors of exclusion. Specifically, NE only reached 22 percent of the poor in 2008, a decline from the 36 percent coverage achieved in 2005. Benefit adequacy (generosity) was quite low, accounting for just 14 percent of total post-transfer consumption of the poorest beneficiaries. The level of benefits eroded over the period 2000-2007. Low coverage and

<sup>2</sup> Over half (56 percent) of benefits paid out were received by those in the poorest quintile and 82 percent of benefits go to those in the poorest two quintiles. This is about average for the ECA region, whose countries show a range of benefits paid out to the poorest quintile from about 30 percent (Russia and Latvia) to about 80 percent (Ukraine and Romania). In terms of leakages, the share of benefits captured by the wealthiest quintile was 6 percent.

benefit inadequacy limited the impact of the NE program on poverty, bringing only 0.4 percent of the pre-transfer poor above the poverty line.

1.6 Over and above increasing budget constraints, a number of design and implementation features further undermined the NE program outcomes. *First*, geographic targeting allocations (block grants) were based on a combination of poverty estimates and historical numbers of beneficiaries for each municipality, but they were not clear and somewhat ad hoc, raising issues of equity and transparency. *Second*, individual eligibility screening, carried out by municipalities, used multiple filters, which differed between urban and rural areas. There was no objective “weighting” across numerous filters, which were applied in an ad hoc way and resulted in the exclusion of otherwise poor households if they failed to meet any one of these filters. Multi-layered filters introduced distortions into the eligibility process both within and across urban and rural areas, resulting in large errors of exclusion and potentially generating adverse incentives. *Third*, inadequate indexation of benefit levels and eligibility thresholds, and inconsistency with other social assistance benefits have contributed to eroding value of NE benefits, a decline in coverage and relevance of the program. *Fourth*, benefits administration was hampered by weak capacity, information systems and oversights and controls. The lack of an automated national registry of applicants and beneficiaries resulted in: (a) inefficiencies in applying for and awarding benefits (with high transaction costs); (b) weaknesses in oversight and controls of fraud and errors; and (c) ineffective monitoring and evaluation of social policy.

1.7 **Social Assistance Priorities.** A number of measures were identified as opportunities to improve the equity, efficiency and transparency of benefits:

- ***basing geographic allocations on objective poverty criteria:*** Transparency and equity could be improved through a standardization of the geographic allocation of block grants across municipalities on the basis of an updated poverty map;
- ***strengthening and standardizing household screening criteria using a continuous scoring formula:*** Eligibility criteria could be standardized and improved by: eliminating the use of one-off binary filters; and (b) strengthening individual assessment criteria using a single continuous scoring formula that incorporates objective weights and variables empirically associated with poverty status (hybrid means testing), which could be adapted for urban (non-farming) and rural (farming) areas. Such a move could reduce errors of inclusion, reduce errors of exclusion (poor families denied benefits due to application of ad hoc filters) and improve transparency in the system;
- ***introducing indexation:*** This would involve the linking of benefits and eligibility thresholds to consumer price inflation;
- ***strengthening benefits administration:*** This would include: (a) automating information systems and creating a national registry of all applicants and beneficiaries; (b) simplifying and standardizing intake and application procedures; (c) improving monitoring, oversight and controls to reduce fraud and errors; (d) possibly shifting eligibility decisions to the central government. These improvements would not only improve effectiveness (equity, efficiency) but would also boost transparency and thereby serve a political role, helping the Government to be more accountable to the people; and

- **improving the links between the NE and other programs:** Both on the administration and policy sides, links (e.g., linking safety nets beneficiaries to activation services) could further contribute to the intended objectives of efficiency and effectiveness.

1.8 **2013 Social Assistance Update.**<sup>3</sup> Building on international experience and a technical partnership with the World Bank, Albania has since taken important steps to improve social assistance program effectiveness. An ambitious reform program is in place to strengthen the design, administration and governance of these transfers. The objectives of this reform program focus on improving the equity and efficiency of the NE program and disability assistance benefits, with the purpose of reducing extreme poverty through: (i) introduction of a unified scoring formula for NE eligibility that incorporates objective weights and variables that are empirically associated with poverty status to reduce errors of exclusion and to improve transparency and revision of eligibility criteria for disability benefits to ensure they reach the truly disabled and vulnerable; (ii) establishment of a Management Information System for both programs to automate and modernize benefits administration; and (iii) strengthening of the system for preventing, detecting, and remedying fraud and errors, which would also improve efficiency for both programs. The World Bank is supporting Albania in the implementation of the social assistance reforms through the Social Assistance Modernization project.

## Health Sector

1.9 **Issues and Challenges.** In 2006 the World Bank undertook an in-depth analysis of Albania's health sector to underpin the preparation of a new health project. It documented the historical shaping of the health care system, characterized by strong central government control prior to the transition, and the consequences on the health system of civil unrest in 1997 and the Kosovo crisis in 1999. Reforms attempted in the mid-1990s to address some of the sector's weaknesses had seen only limited progress, including: reduction in the (overextended) provider network capacity; decentralization of primary care management to district public health directorates and its integration with public health functions; the privatization of the pharmaceutical sector and most dental care; and establishment of the Health Insurance Institute (HII), in view of a gradual aspired change of the health financing system. Substantial improvement of the quality of the primary care system through physical investments and skills upgrading was also envisaged, but interrupted by the Kosovo crisis. Pilot projects on provider organization and financing undertaken in the early 2000s yielded valuable lessons. And some progress on pharmaceutical policy was also made.

1.10 Nevertheless, the 2006 sector analysis pointed to significant challenges in responding to Albania's changing demographic and epidemiological profile. *First*, Albania's health outcomes compared favorably with those of lower middle-income countries outside the Europe and Central Asia region, but lagged behind those of other countries in the South East European Region, despite progress achieved. Albania's demographic and epidemiological profile was changing with the relative burden of infections diseases decreasing and non-

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<sup>3</sup> World Bank Group Policy Brief on Improving Poverty Monitoring and Social Assistance, prepared for the briefing of the new Government, September 2013.

communicable diseases becoming the leading cause of death among the adult population. *Second*, Albania's health care system was ill-prepared to face the growing incidence of non-communicable diseases and other new health risks. *Third*, physical and human resources in the sector were ill-aligned with the population's health needs, their inequitable distribution causing large variations in coverage across districts and regions.

1.11 *Fourth*, productivity in the health sector was low, both for primary and hospital care, with substantial variation across regions and individual facilities. Furthermore, a large number of small hospitals with low utilization and occupancy rates revealed an inefficient hospital structure. *Fifth*, quality of health care was low, particularly at the primary care level. A survey on reproductive health found that quality and coverage of prenatal care was a serious concern and ranked among the lowest in the ECA region. Health personnel were isolated and lacked in-service training to upgrade their skills. Quality improvement was a core objective of the Government's Health Sector Strategy of 2004. *Sixth*, in light of a small but growing private health care sector, the need to strengthen the regulatory framework took on more prominence.

1.12 *Seventh*, building on progress made in the pharmaceutical sector, further steps were necessary to contain costs, improve the transparency of decision-making and strengthen quality assurance. Substantial steps were taken to improve transparency along the distribution chain and to institute cost containment on HII reimbursed drugs. *Eighth*, low income groups were unprotected from health shocks and easily thrown into poverty as a result of out-of-pocket (OOP) spending on health care. The 6 percent of GDP which Albania spends on health care is in line with the average for lower middle-income countries, but Albania's public sector contributes a below average share to these expenditures. The high share of OOP payments at the point of service and outside an overall health finance framework created serious inequities in access, had a considerable poverty impact and limited effectiveness of the Government's sectoral stewardship. *Ninth*, the health financing system was fragmented. It neither gave providers incentives for efficiency and quality improvements nor did it establish clear lines of accountability. The continued fragmentation of the health finance system and at times unclear assignment of financing responsibilities had resulted in a lack of accountability for sectoral performance in general and individual providers' performance in particular.

1.13 **Health Sector Priorities in 2006.** This analysis culminated in the identification of a prioritized agenda for improving health sector performance. The main challenge for Albania's health sector was to consolidate the achievements in health outcomes to date, while establishing capacity to effectively address the growing incidence of non-communicable diseases and affording low-income groups better protection from impoverishing health expenditures. This would require fundamental changes in the way health care is financed, delivered, and organized, with efforts clustering around three core pillars:

- ***more efficient resource mobilization and allocation***, including, *inter alia*: pooling all public sector resources under one funding agency, clearly defining the health care benefit, which will be made available from public funds and introducing copayment for a wider range of services, rooting out informal payments, increasing resources for public health and health information, shifting to a population-based regional allocation of funding,

improving the balance between public and private spending to protect the population from health shocks, using a hospital map to guide any future investment in hospital infrastructure, and developing regional primary health care plans;

- **improvements in the quality and efficiency of health service delivery**, including: consolidating pilot efforts to improve clinical effectiveness and quality of care, shifting from input-based financing of health care providers to performance-based payments, establishing a quality assurance system, and consolidating reforms in the pharmaceutical sector; and
- **improvements in sector management and stewardship**, including: defining roles and responsibilities of all actors and establishing accountability mechanisms, reviewing the potential role of regional health authorities and making a decision about their future, evaluating the feasibility of independent contracts with general practitioners for primary care and other organizational arrangements, increasing hospital autonomy and intensifying efforts to systematize and use population feedback and community participation in the design and implementation of reforms and in monitoring sector performance. The changes in the organization and financing of health care require capacity building of health care providers, HII and the Ministry of Health (MoH).

1.14 Soon after this sector analysis was issued, Government articulated four strategic priorities in its “Health System Strategy 2007-2013,” which are consistent with the above-identified priorities: (1) increase the capacity to manage services and facilities in an efficient way; (2) increase access to effective health services; (3) improve health system financing; and (4) improve health system governance.

1.15 **2013 Health Update.**<sup>4</sup> Health outcomes are relatively strong by regional standards, with life expectancy at birth reaching 77 years by 2011 (80 for women and 74 for men). The Mediterranean diet has been posited as a major explanation for these relatively good indicators. Cardiovascular disease is the major source of the disease burden, major risk factors including tobacco use and hypertension. The most recent (2008) Demographic and Health Survey (DHS) revealed that 80 percent of women and 90 percent of men with hypertension were not aware of their status and less than 3 percent were both aware of their high blood pressure and had it under control through treatment, indicating substantial room for improvement of health system performance. Child health indicators (infant and neo-natal mortality at 18 and 11 per 1,000 live births, respectively, 2008 DHS) are slightly higher than comparable statistics for other countries in southeastern Europe. The quality of medical care at all levels of the health system remains a major issue in Albania.

1.16 Financial protection of households against high OOP payments is relatively weak. OOP payments for health care continue to be substantial in Albania with important implications for household budgets; and they also result in significant inequality. A combination of measures will be needed to reduce Albania’s reliance on OOP payments and improve financial protection, especially increased Government spending on health. However, such increases may not be feasible within the current difficult fiscal environment.

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<sup>4</sup> World Bank Group Policy Note on Albania Health Sector, prepared for briefing the new Government, September 2013.



Nevertheless, other measures could help, especially reduction of informal payments, including stronger accountability of providers, government oversight and empowerment of patients with information about what they should pay. Additionally, clear drug lists, treatment protocols, generic promotion and price regulation could help reduce unnecessary or wasteful pharmaceutical expenditures.

1.17 Health spending is not very efficient, which is a critical issue especially in the current difficult fiscal environment. Common sources of waste include excess hospital infrastructure and high pharmaceutical spending. Variation in outputs and outcomes across different providers and services are not sufficiently tracked or addressed. Inequitable distribution of health services remains an issue, as do continued inefficiencies in the use of the referral system.

1.18 A major priority for the health financing agenda should be stronger revenue mobilization and pooling of health care resources, subject to the availability of resources in a difficult fiscal environment. This would address the persistently high reliance on OOP payments for public sector services, especially by the poor, an inefficient and inequitable method of health finance. Albania's new Government is now considering the option of transitioning from primarily payroll-financed to general tax-financed health system. Currently, provider payment methods rely more heavily on input-based approaches than is the case in more advanced health systems. A shift towards outcome-based approaches may help improve health outcomes and efficiency.

### **World Bank and Other Support to Health and Social Assistance**

1.19 **World Bank Support.** Annex D shows three clusters of World Bank support relevant to the evaluation of the social assistance and health projects that are the subject of this review. Three Poverty Reduction Strategy Credits, approved, respectively, in 2002, 2003 and 2004 and totaling US\$48 million in IDA credit, supported implementation of Albania's poverty reduction strategy, with a particular focus on policies for improving the quality of life, especially for the poor, and for improving the accountability and performance of social sector service delivery. The outcomes of all three projects were in the satisfactory range.

1.20 The Bank's first investment in social insurance and social assistance program reform was through the Social Safety Net project, approved some 20 years ago, in 1993. This project succeeded in consolidating reform of these programs and bringing social policies in line with a decentralized democratic society and a transitional economy. The Social Services Delivery Project, approved in 2001, made important headway in improving standards of living for the poor and vulnerable by increasing their access to well-targeted and effective social care services and improving social policy. The Social Sector Reform Development Policy Loan (evaluated in this PPAR) was approved in 2011 to support policy changes to improve the effectiveness of social safety nets and enhance the efficiency and equity of health spending in a fiscally sustainable environment. Lessons incorporated into its design highlighted the importance of: complementing this policy loan with implementation support and technical assistance under investment operations; a focus on two (social) sectors versus many sectors; and strong government ownership. The ongoing Social Assistance

Modernization Project (SAMP), approved in 2012, is supporting Albania's implementation of reforms to improve the equity and efficiency of its social assistance programs. Total World Bank investment in social protection, including the ongoing SAMP, amounts to US\$95.5 million, of which \$15.5 million was IDA credits and US\$80 million IBRD loans.

1.21 The Bank has invested in Albania's health sector through four projects over 20 years, with credits totaling about US\$50.0 million. Approved in 1994, the Health Services Rehabilitation project aimed to help prevent deterioration in health status during the economic transition by improving the quality of basic health care. The Health System Recovery and Development project, approved in 1998 and overlapping with the first project, supported strengthening of institutional and human resource capacities and aimed to improve quality, accessibility and efficiency of essential health services. Its moderately unsatisfactory outcome culminated in lessons, among which the importance of: (i) including benchmarks among M&E indicators; (ii) continuity in key leadership positions; and (iii) including significant, focused technical assistance and capacity building activities. Drawing on these lessons, the Health System Modernization Project (HSMP), approved in 2006 and the subject of this PPAR, aimed to improve: the capacity of the Ministry of Health and the HII to effectively formulate and implement health policies and reforms; access to and quality of primary health care services, especially for the poor and underserved; and hospital governance. Also approved in 2006, and closed in 2010, the Avian Influenza Control Project had a moderately satisfactory outcome.

1.22 **Other main actors** supporting Albania's health system improvements include: USAID, the Italian Cooperation, the OPEC Fund, the Swiss Development Cooperation, SIDA, UNICEF, UNFPA and WHO. Working especially closely with the Bank: (1) USAID provides technical and financial support to improve primary health care services and to inform and implement sector reform, especially in the areas of health financing, quality assurance, hospital management and health information systems; (2) the Swiss Development Cooperation supports health services quality, especially through training and the establishment and support of the Continuing Medical Education (CME) system, and primary health care services; WHO provides technical advice and backstopping on the control of specific diseases, health systems strengthening, stewardship and performance management, and, in collaboration with the Bank, undertakes a development partner coordinating function. The Bank is the only major donor supporting social assistance reform.

## 2. Health System Modernization Project

### A. Objectives, Design and Their Relevance

2.1 **Project Development Objectives (PDOs).** As stated in the Financing Agreement (FA) (April 22, 2006), “The objectives of the Project are: (a) to improve the physical and financial access to, and use of, high quality primary health care services; (b) to improve the Recipient’s capacity to formulate and implement health policies and reforms in the health sector; and (c) to improve hospital governance and management.” The Project Appraisal Document (PAD)’s statement of objectives is fully consistent with that of the FA, but provides more detail on the project’s intent, including: an emphasis on improving primary health care for the poor and under-served areas; and the expectation of reductions in the unnecessary use of secondary and tertiary care facilities through improved PHC services. The objectives remained unchanged throughout the life of the project.

2.2 **Relevance of Objectives is rated High.** *First*, these objectives are very responsive to current country conditions. Physical and financial access to quality services at the primary level may have improved somewhat in the past few years, but remain issues, especially for the poor and in remote areas. MoH and HII have articulated and begun to implement health financing and health systems performance policies and reform, but there is still an important agenda for additional sector reform and its implementation. Staff turnover and the election of a new Government, with its vision of continued and deepening health financing and health system reform, indicate continued strong relevance of capacity building in reform design and implementation. Weak hospital governance and management remain critical impediments to expenditure efficiencies.

2.3 *Second*, the objectives are highly relevant to Albania’s strategic priorities. Albania’s Health Sector Strategy is articulated around four priorities to improve: efficient management of services and facilities; access to effective health services; health system financing; and health system governance. The recently elected government has embraced these priorities and stands ready to continue efforts and reforms aimed at service quality, access and affordability; greater equity and efficiency of financing; and enhanced autonomy and management of services. *Third*, the second pillar of the World Bank’s current Country Partnership Strategy (CPS) for the period FY11-FY14 aims to improve social service delivery, with a focus on: poor people’s access; governance issues; spending efficiencies; and decentralized service delivery. The World Bank’s health strategy aims to: (1) improve health outcomes, particularly for the poor and vulnerable; (2) prevent poverty due to illness; (3) improve financial sustainability in the health sector; and (4) improve health sector governance, accountability and transparency.

### Box 2.1. Health System Modernization Project Components

**Component A – Strengthening Sector Stewardship, Financing and Purchasing (estimated cost at appraisal: US\$7.7 million; total actual cost: US\$4.7 million)** was designed to help the HII develop its capacity as the sole purchaser of health services, and to support capacity building to strengthen the stewardship role of the MoH, the Institute of Public Health (IPH) and the HII. Activities were to include: (i) capacity building in the HII and its local branches; (ii) strengthening the policy formulation and performance monitoring functions within the MoH and the IPH; (iii) development of health information systems to support payment and management reforms; (iv) development and implementation of a system to monitor provider performance (both clinical and financial); (v) establishing a licensing/re-licensing scheme for physicians and health facilities and an accreditation program for hospitals; (vi) development of Health Technology Assessment (HTA) capacity; and (vii) building up MoH capacity in financial management, procurement and project coordination.

**Component B – Improving PHC Delivery (estimated cost at appraisal: US\$10.1 million, total actual cost: US\$12.5 million)** was designed to support institutional reforms and limited investments aimed at improving quality of care among health care providers and in health facilities. The Program aimed to: (i) facilitate registration of the population with the HII and enrolment with a primary care physician, together with related public information campaigns;<sup>5</sup> (ii) build practice management capacity at the primary care level; (iii) develop and introduce clinical guidelines with an initial focus on primary care and the primary-secondary care interface and the most pressing issues (e.g., child health, antenatal care, respiratory infections); (iv) establish a continuing medical education system (CME) and link this to the re-licensing scheme; (v) retrain existing general practitioners and pediatricians in evidence-based treatment of common conditions and rational drugs use, based on clinical guidelines; (vi) provide basic equipment to physicians who complete the retraining program; and (vii) establish a grant facility to fund proposals from primary care providers in support of quality of care and continuum of care improvement initiatives.

**Component C – Strengthening Hospital Governance and Management (estimated cost at appraisal: US\$1.3 million; total actual cost: US\$1.8 million)** was designed to provide initial steps to improve hospital operations and direction by focusing on (i) the development and introduction of accounting and internal control structures for hospital care providers and training in hospital management; (ii) developing the regulatory framework, including by-laws and regulations to support the move of MoH hospitals to the status of autonomous public entities; and (iii) piloting reforms of hospital management and governance structures in selected hospitals.

*Source:* PAD p. 6.

**2.4 Design.** The project supported three components outlined in Box 2.1. Two restructurings (April 2010 and September 2011) added and dropped activities. Under Component A the procurement of software for the health information system was dropped and only the hardware was maintained, due to delays in the system design. Under Component B: (a) only health insurance cards for children ages 0-16 years were financed, because Government decided to devote space for health on a new national identification to be issued by Ministry of Interior to the entire adult population (ages 17 years and older); (b) financing of the costs of registration/enrollment was dropped because of delays in the design of the information system; (c) purchasing of specialized medical equipment (mammography equipment and autoclaves) was added for selected main hospitals, along with medical equipment for regional hospitals and Tirana University Hospital; (d) a national communication strategy for health was added; and (e) the quality grant facility was dropped

<sup>5</sup> To promote a rapid registration and enrolment process, associated costs were to be reimbursed on an output basis, including the cost of the registration card, plus an estimate of the additional staff needed to register each individual. Staff costs were to reflect the incremental HII staff time needed to process each registration/enrollment, using average salaries. The amount was to be agreed to by the Bank prior to the release of disbursements.

due to lack of action and interest on the part of Government. Two activities were added to Component C: technical assistance to prepare and implement the privatization of all non-medical activities in the regional hospitals; and pilot testing of the hospital rationalization strategy in two selected districts.

**2.5 Relevance of Design is rated Modest. *The results chain for achieving PDO 1 was somewhat weak.*** In support of improved quality of services, interventions were appropriate both at the policy level (supporting licensing and accreditation functions and processes and the production of Clinical Practice Guidelines) and at the facility level (training of service providers in the application of CPGs, provision of basic equipment for services, a quality innovation grant, and bonuses for service providers on the proper delivery of priority services). But there were shortcomings. The links between investments and the goals of physical and financial access were not entirely clear, nor were the links among the several loosely related sub-objectives embedded in this objective. Registration and enrolment of the population is a necessary administrative step to underpin the transformation of health financing for PHC, whereby budgets are determined on the basis of capitation versus inputs. Enrolment with a primary physician is not necessarily indicative of having no previous access to that physician or of improved access. Other than the provision of PHC equipment, there were no interventions to address the main impediments to physical access, including the inequitable distribution of PHC centers and providers, low physician to population ratios especially in rural areas, and issues associated with the affordability and availability of essential drugs, among others. Training and other support appeared to be limited to physicians, even though nurses play a critical role in the delivery of PHC. Financial access was to be improved by stepping up health insurance registration and clarity on pricing of services. But a formidable impediment to financial access – informal payments – was not squarely addressed. A public campaign to inform the population about the proper use of the referral system and related health insurance incentives was inadequate to change behavior. The assumption that knowledge of the rules would incite the proper behavior was weak.

**2.6 *The results chain for achieving PDO 2 also had some shortcomings.*** The goal of strengthening financing and purchasing of health services under a single agency was appropriately supported with planned activities under the project. While the goal of strengthening sector stewardship was well supported with critical intermediate outcomes (development of a sector strategy, an M&E system and capacities, and a practice of regular annual sector performance reviews), the project results chain would have been stronger had the roles, responsibilities and accountabilities of key sector institutions been clarified. This is especially true for MoH, which was transitioning away from financier and overseer of health services (assumed by HII) to its evolving role as the national authority charged with sector strategic management and coordination, policy formulation and enforcement. The roles and capacities of regional and district levels of MoH were also neglected in the design. The roles and inter-relations between MoH and other health sector institutions, particularly the National Center for Quality, Safety and Accreditation (NCQSA) and the Institute of Public Health (IPH), would also have benefited from clarification. These elements were highlighted as priorities in the Bank's analytic work, discussed and agreed with MoH in 2006 (para. 1.13). ***The results chain for PDO 3 was appropriate,*** involving the development of new management systems and capacities, the development of a regulatory framework for autonomy and the piloting of reforms. The overly ambitious timeframe of the project was a

design shortcoming. However, on the financial front, the design did hold the potential to achieve efficiencies in the use of sector resources, especially crucial in the face of fiscal constraints.

### 2.7 *The two project restructurings further weakened the project's results chain.*

Acquisition of sophisticated cardiology and pediatric surgical equipment for Tirana University Hospital, specialized medical equipment (mammography and autoclaves) for a few main hospitals, and equipment for 12 regional hospitals was meant to (a) improve the quality of referrals between primary and hospital levels; and (b) support the implementation of the hospital rationalization plan, which recommended the strengthening of the regional hospitals. But neither these purchases nor their rationale directly support the project's PDOs. These purchases were added after the project's mid-term review, when a very low disbursement rate of 7 percent raised the serious concern of Bank managers, along with their push to accelerate disbursements or cancel a portion of the credit. The dropping of the quality grant facility weakened the results chain supporting improvements to service quality. The dropping of software for the health information system, while maintaining the purchase of hardware, weakened the results chain for achieving a viable health information system. The pilot testing of the hospitalization rationalization strategy in two districts was a positive addition. Annex E, Table E-1 itemizes changes to components and restructuring dates.

2.8 **M&E Design.** The original M&E design included indicators that were fairly sufficient to measure progress against the PDOs. Arrangements for results monitoring were laid out, most baselines were established, target values were set for each project year, and data collection and reporting were specified on three fronts: frequency and reports; data collection instruments; and responsibility for data collection. The key performance indicators and intermediate outcome indicators together had the potential to track progress against project objectives and link them to project support. The adding and dropping of indicators under the April 2010 project structuring weakened the M&E design. Project objectives were not changed, and the rationale for revising the M&E design was to simplify it and to ensure that indicators were measurable. In actual fact, the indicators that were dropped were key to understanding progress against objectives (e.g., physician compliance with clinical practice guidelines) and those that were added were more output or process oriented (e.g., improved capacity of regional hospitals through supply and functioning of essential medical equipment, production of health strategy). Moreover, a number of the new indicators were ill-defined and unclear. In short, the measurement of efficacy was weakened with these changes. Annex E, Table E-1, provides a tally of both indicators and activities that were added and dropped for each of the two restructuring exercises: April 2010 and September 2011. Annex E, Table E-2 compares original and revised indicators.

2.9 **Implementation Arrangements.** The project was to be implemented by the MoH and the HII, using existing structures and staff. The Deputy Minister responsible for international cooperation was executive sponsor, and the Director of the Economic Department was responsible for handling day to day project management, with support from foreign and local consultants in the application of World Bank fiduciary procedures. Country systems would be used to the extent possible. Working groups, and chairpersons, were appointed by the Minister to focus on each of three substantive areas: health financing; quality; and governance and management. They were responsible for coordination and

technical management of project activities, including linking with stakeholders beyond the groups' members.

2.10 Strengthening of MoH's reform articulation and implementation was to be supplemented by international expertise initially. The bulk of this assistance was allocated to MoH's Policy and Planning and Monitoring and Evaluation Sectors, IPH's Public Health Policy Development Sector and HII's Service Monitoring Department, among others. The Chair of Family Medicine was to be developed to take on a leadership role in family medicine and general PHC training. The Financing Agreement included conditions of effectiveness requiring ongoing maintenance of these units.

## **B. Implementation**

2.11 **Key Dates.** Approved by the Board of Directors on March 14, 2006, the IDA credit became effective on September 7, 2006. The mid-term review took place in December 2008. Two Level 2 restructurings were approved, respectively, on May 3, 2010 and on October 24, 2011. *The first restructuring* occurred five months before the project was scheduled to close, but only one third of the credit proceeds were disbursed. It involved the addition of four activities,<sup>6</sup> the most significant being the purchase of hospital equipment, and the dropping of the quality improvement grant facility. *The second restructuring* dropped software procurement for the health insurance information system and support to the registration of the population with the HII, and added the pilot testing of the country's hospital rationalization strategy.

2.12 The original closing date of September 30, 2010 was extended twice to June 30, 2012. The first extension of 18 months was granted under the first restructuring in order to complete: (i) the procurement of medical equipment for the regional hospitals; and (ii) the health insurance system, including health identification cards for children 0-16 years. The second extension of three months was granted in February 2012 to allow completion of procurement of two big packages of medical equipment.

2.13 **Planned versus Actual Costs, Financing and Disbursements.** The total project cost was US\$19 million equivalent, almost exactly the appraisal estimate. But the allocation of expenditures across project components changed, as indicated in Table 2.1. The actual cost of Component A was US\$3 million less than planned, while the cost of Component B was US\$2.4 million more than planned and the cost of Component C increased by US\$0.5 million. These changes were due to the additions and deletions of activities under the formal restructurings co-signed by the Government of Albania and the World Bank.

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<sup>6</sup> May 2010 Restructuring additions: new national communications strategy and campaign on PHC/quality improvements; production of health identity cards for enrollment in primary care; purchase of hospital equipment; and support for the contracting out of all non-medical activities in regional hospitals.

**Table 2.1. Planned versus Actual Costs by Project Component (US\$ million)**

Component	Planned	Actual	
A. Strengthening Sector Stewardship, Financing and Purchasing	7.7	4.7	61%
B. Improving Primary Health Care Service Delivery	10.1	12.5	124%
C. Strengthening Hospital Governance and Management	1.3	1.8	139%
Total Project Costs	19.1	19.0	100%

*Source:* Implementation Completion Report and Project Implementation Unit.

2.14 These formal restructurings also involved the reallocation of the IDA credit across the various disbursement categories. Annex F shows the original allocation of the credit proceeds, the two reallocations agreed under the two restructuring exercises and the actual use of the credit proceeds. An amount of SDR 9.41 million was actually disbursed, and SDR 1.29 million was cancelled, including an amount of SDR 0.7 million cancelled due to misprocurement for a package of hospital equipment. This amounts to a disbursement rate of 88 percent of the original credit amount of SDR 10.7 million. The Japanese Trust Fund of US\$1.6 million was fully utilized and the Government of Albania financed a total of US\$2.9 million, or 140 percent of its original commitment of US\$2.1 million.

2.15 **Factors Affecting Implementation.** Factors, which affected implementation but were outside of MoH's control, were political in nature. The center-right Democratic party won the 2009 elections by a narrow margin. The opposition Socialist Party carried out a series of demonstrations alleging vote-rigging and led a campaign of civil disobedience until a recount would be undertaken. Demonstrations flared up again in 2011 around allegations of corruption and election rigging. In late 2013 the Socialist Party won the elections and a new Government was established. These political events caused disruptions and delays in implementation.

2.16 Staff turnover significantly undermined the pace of implementation. There was on average one new Minister of Health appointed per year during the life of the project. Turnover of high-level staff within the Ministry was pervasive, prompted mostly by political factors, causing a loss of experience and institutional memory with new appointees not always having the requisite capacity. Informants were consistent in mentioning this phenomenon noting that it transcended central-level health institutions and pervaded at the hospital and health facility level (especially hospital directors). Other factors, which slowed implementation, included: the illness of the Deputy Minister responsible for project oversight; tensions between MoH and HII, largely centered around a lack of clarity of roles, responsibilities and accountabilities; long delays in the establishment and functioning of the three technical working groups; delays in appointing counterparts for technical assistants hired under the project; and failure of HII to make critical decisions on health information system design to permit the procurement of software. The preparation and implementation of the health component of the Social Sector Development Policy Loan (DPL) brought more synergies to the work under the project to move forward with health financing reforms.



**2.17 M&E Implementation.** There was reporting on the revised indicators, but the implementation of M&E fell far short of what was envisaged in the design. Because of the lack of clarity in the definition and statement of many indicators, it is difficult to understand exactly what the data means, what was being measured, what were the numerators and denominators being used. The LSMS 2012 was to be an important source of data for assessing efficacy, but the results of this survey were not available during IEG's mission (November 2013) or during the data analysis phase of this evaluation (January-April 2014). LSMS 2012 data have since been made available for the World Bank's recent Public Finance Review (World Bank 2014). The Bank's secondary analysis of these newly available data corroborates the findings of this evaluation and is appropriately cited in this report. The preparation of annual sector performance reports was required under the project's financial agreement, but only two were submitted (in 2011 and 2012). While these reports were prepared on the basis of the sector M&E indicators developed and adopted under the project, their quality and utility are reported to be weak. The development of productivity and performance indicators under the HII bonus payment scheme was a step forward in tracking performance at the PHC level. However, there appears to be very little compilation and analysis of data and trends at the central level (HII and MoH included), and even less so at the regional and district levels of HII and MoH.

**2.18 Safeguards Compliance.** No safeguards were triggered under this project.

**2.19 Fiduciary Compliance.** Financial management was carried out in accordance with Bank requirements. Internal controls, staffing, reporting and auditing arrangements were all sound; and the financial specialist responsible for the project possessed the requisite skills and abilities. Audits were completed on time and none were qualified. The quarterly financial reports were mostly submitted on time. Internal controls included regular reconciliation of bank accounts, adequate segregation of duties and monthly reconciliation of the Bank's disbursement summaries with project accounting records.

**2.20 Procurement** under the project followed the Bank's guidelines. Lack of capacity to prepare technical specifications for medical equipment caused delays in the preparation of bidding documents. The project suffered implementation delays due to complaints received at various stages of the procurement process for medical equipment: bidding period, evaluation and contract award. The Bank declared mis-procurement on one lot of medical equipment worth US\$1.1 million. The evaluation committee disqualified the lowest evaluated responsive bidder, based on an evaluation criterion not specified in the bidding documents, and recommended award to another bidder, in violation of the Bank's guidelines. With the exception of this incident of mis-procurement, there were no other major issues. The selection of consultants for the large portfolio of technical assistance was well executed.

### **C. Achievement of Objectives<sup>7</sup>**

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<sup>7</sup> For the record, Annex E, Table E-2 presents original and revised project indicators, their baselines, targets and (as available) their end-line data. IEG's assessment of efficacy draws on this information, only to a limited extent because (1) indicators did not fully capture progress against the objectives; and (2) many of these indicators were not monitored, or they had end-line data that were unclear and/or unreliable.

2.21 This section assesses the achievement of project objectives and links between the project's support and outcomes. However, it is important to note that the Bank was one among several development partners working in support of similar objectives. USAID supports primary health care services, quality assurance, health financing reform, hospital management and health information systems. WHO provides advice and assistance on health systems strengthening and performance management. The SDC supports primary health care delivery and quality assurance. Thus, outcomes assessed in this section cannot be solely attributed to the Bank's support.

**PDO #1: Improve the physical and financial access to, and use of, high quality primary health care services, with an emphasis on those in poor and under-served areas, as well as to diminish the unnecessary use of secondary and tertiary care facilities. – Modestly Achieved**

2.22 This section assesses the various sub-objectives embedded in this statement of objectives: physical access, financial access, use, quality of primary health care services, with equity, and reduced unnecessary use of hospital services, all with an emphasis on the poor and vulnerable. With few exceptions, reliable data to track efficacy on these various fronts are not available. As a consequence, this assessment of efficacy is based on evidence drawn from IEG's interviews with a wide range of stakeholders, its direct observations during field visits, and various studies available on the PHC sector. One study in particular provided invaluable insight on the population's own assessment of the health care system. Undertaken in 2013, USAID's formative research on consumers' perspectives is summarized in Box 2.2., with additional specific elements woven into the relevant analyses of the various sub-objectives. In short, the findings of this study document significant shortcomings, from consumers' perspectives, in PHC, access, quality, equity and effective use of the referral system. This corroborates findings derived from field visits, interviews and other studies, including a recently completed World Bank public finance review (World Bank 2014). But it is important to note that there was no baseline study, which makes it impossible to document trends.

2.23 **Physical Access.** The project invested in three key inputs to improve the population's physical access to primary health care services. *First*, it provided basic furniture to 2,200 facilities, including *ambulancias* (very basic health posts) and PHC centers. *Second*, the project provided essential medical equipment to all PHC centers, as well as basic medical supplies for delivering the PHC package, encompassing diagnostic and treatment services for patients, with a particular focus on the management of chronic diseases. Some ambulances were also provided. *Third*, while the project financed the retraining of primary health physicians in evidence-based treatment of common conditions, it did not add to the quantity of physicians providing primary health care in Albania, nor did it support a more equitable distribution of physicians across and within regions.

## Box 2.2. Consumers' Assessment of the Health Care System in Albania

### Health Insurance and the Referral System:

- Despite widespread knowledge of the insured on how to access and use the system, family physicians are often bypassed in favor of hospital care, due to the perception of poor quality of care at the primary level.
- Public healthcare costs seem to be prohibitive for those without health insurance, resulting in limited access to services for the poorest and most vulnerable. Instead they refrain from contacting public facilities altogether, access the system through emergency services, or seek pharmacists' advice.
- Potential beneficiaries of health insurance coverage (those not formally employed) are not aware of their eligibility to access coverage. Formally employed citizens consider health insurance to be a "tax" because it does not guarantee protection from out of pocket payments.

### Informal Payments:

- Informal payments are considered by many to be absolutely essential to gaining access to health services and to receiving good quality services.
- The act of providing a bribe to health providers is accompanied by a strong feeling of powerlessness towards health providers, motivated by the desire to feel less afraid of, and more confident in, the quality of services they will receive.
- With a few exceptions, the majority of respondents think that health providers are not sufficiently devoted to providing good quality of care, lack professionalism and display poor communication ethics in their interactions with patients. The lack of providers' accountability to health consumers is the main reason for their poor performance.

### Information on Health and Health Care:

- The majority of respondents affirmed that their communities are not sufficiently informed about health, preventive health care and health insurance. Priorities seem to be focused more on treatment than prevention, with many seeing a doctor very late in an illness, when options are few.
- Very limited health information received from physicians seems to be supplemented by pharmacists, who are trusted and influential. Other trusted sources include: family elders, relatives, friends, the media.
- Focus group discussions reveal very limited information on the Patients' Rights Card.

### Health System Accountability:

- Respondents feel powerless to react to injustice in the health center. Some expressed that they are discouraged from demanding equal and quality treatment because they believe that there is no true accountability to the client and fear even worse treatment if they speak up.
- They feel that an effective consumer feedback mechanism should be impartial, professional, independent from health providers and sufficiently powerful to have an impact. Also important is the need to tailor such a mechanism to accommodate diverse patient groups, especially rural/urban and age differentials.

### Civic Engagement:

- Citizens feel detached from the needs of their communities and focus only on their personal interests.
- Respondents expressed skepticism on the role and impact of civil society, many lacking awareness and understanding of the role and presence of NGOs and expressing concern about the political motives and lack of transparency of NGOs.
- Nevertheless, some acknowledge the good work of some civil actors in Albania.

*Source:* "Health Care System in Albania, A Formative Research with Consumers to Increase Non-State Actors' Engagement in Health System Governance," USAID, May 8, 2013.

2.24 These investments notwithstanding, *IEG was unable to find evidence of improvements to physical access*.<sup>8</sup> MoH does not have data on trends in physical access to

<sup>8</sup> For the purposes of this report, physical access is defined by the population's reasonable proximity to a well-equipped primary health care facility with adequate staffing and supplies, capable of delivering the full package of preventive, promotional, treatment and curative services.

primary health care.<sup>9</sup> It is plausible to assume that improvements to infrastructure and additional equipment and supplies supported under the project have translated into some improvements in physical access. Indeed, respondents have noted their appreciation of equipment received through the project. But there are still major issues undermining physical access. The above-cited USAID study reveals that poor physical infrastructure and lack of equipment and supplies remain major impediments. This includes the physical conditions of health facilities and their ineffective operation and maintenance and lack of basic furniture (bed/bed linens, chairs and other basic furniture) in all three regions covered in this study. IEG's visit to Elbasan and exchanges with local level-level officials corroborate these findings. Over and above the low doctor to patient ratios, especially in the rural areas, interviews and USAID's consumer survey document limited availability of physicians in PHC centers. Some curtail their time in the public facilities to work (as well) in the more financially rewarding private facilities; and some keep very short hours in rural facilities because they continue to live in cities, with long commute times. All sources did reveal improved access to services resulting from recent substantial improvements in main roads in Albania. But these improvements were noted specifically to have brought improved access to health facilities in Tirana, and not to PHC. Korca consumers raised issues of limited access to ambulance services and (especially in urban Korca) ineffective ambulance services. Finally, multiple sources were consistent in documenting very limited access to health promotion and outreach services, which are a critical component of the PHC package.

**2.25 Financial Access.** Planned project support to improve financial access to services included: financing of the administrative costs of registration with the HII of those eligible for health insurance and of their enrolment with a primary care physician; the establishment of an information system to support and track this registration/enrolment; public information campaigns to explain insurance coverage and the proper use of the referral system, requiring visits to the primary care physician and limiting hospital visits only to those referred by a primary care physician; and technical assistance in the design of the new health financing law.

**2.26** In the end, the Government decided to cover its own expenses with regard to the registration of the eligible population with HII and their enrolment with a primary care physician. According to HII's Annual Report 2012 (HII, 2013), an estimated 1.7 million people, or 53 percent of the entire population, are covered by health insurance and enrolled with a primary care physician, as indicated by the total number of health booklets in circulation. This represents an increase of 146,000 (or 9 percent) over the previous year, but it falls short of the project target of 70 percent.<sup>10</sup> Only the hardware was purchased for the HII information system, the software delayed beyond the project's capacity to purchase it,

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<sup>9</sup> Attempts to register population with the HII are indicative of financial access, not physical access (see following section). And enrolment of the population with a primary care physician (see section on efficacy of PDO# 2) is a mechanism for introducing/facilitating health financing based on capitation, and not an indicator of physical access.

<sup>10</sup> While the project set this as a target linked to improved access, enrolment with a physician is not an indicator of improved access, as those enrolled would have had access to their local primary care physician even without being enrolled. It is, rather, a measure to underpin the new way of financing primary health care, based on capitation. This is discussed further under PDO#2.

due to indecision by HII on the type of system needed. Public information campaigns were carried out with project support. Passed in 2011 and effective in March 2013, the health financing law clarified that health insurance is compulsory for all economically active people<sup>11</sup> and covers (under State financing) specific categories of economically non-active people.<sup>12</sup> This law, whose technical preparation was supported with project-financed technical assistance, extended free coverage to all beneficiaries of the NE/social assistance program.

**2.27 *There appears to be no substantial improvement to financial access.*** While the health financing law (whose passage was supported under the Social Sector DPL; see Chapter 3) extends coverage to NE program beneficiaries, Government has held off implementing this reform because of fiscal constraints (paras. 3.40-3.41). Other potential (non-economically active) beneficiaries, particularly the unemployed, appear to be unaware of their eligibility and/or of procedures and documentation to secure coverage (USAID, 2013). Insurance coverage of the poorest quintile has increased between 2008 and 2012, from 27 percent to 52 percent, at a faster rate than for the richest quintile (from 54 percent to 67 percent) (World Bank 2014). Still the share of households that are pushed into poverty by health spending has increased between 2008 and 2012 (World Bank 2014; see also para. 3.42). Whether insured or uninsured, informal payments are raised by virtually all informants and numerous studies as a significant impediment to access. Consumers declare (USAID, 2013) that almost all public health employees (security staff, hygiene and cleaning staff, nurses, physicians, among others) require to be paid informally, independent of patients' health insurance status. Reasons consumers feel compelled to pay bribes include: gaining access to health services; receiving better quality care; receiving sufficient information/an accurate diagnosis; and curtailing excessive bureaucracy of the referral system. A recent survey corroborates this phenomenon, with 39 percent of respondents reporting that informal payments are usually needed to obtain health services.<sup>13</sup> While these sources indicate that informal payments are pervasive, the World Bank, based on LSMS data, estimates that informal payments may represent only 5 percent of OOP spending. On the other hand, an estimated 50 percent of OOP at PHC facilities is for prescription drugs, an indication of ineffective coverage of health insurance for this expenditure. Almost 90 percent of OOP occurs at public facilities.

**2.28 *The uninsured (mostly poor populations) do not have full access.*** The Roma are not aware of free access accorded to pregnant women, children, retired, invalids. And sometimes they are required to pay for services that should be free. The Public Health Directorate is currently reaching out to Roma people to inform them of their rights and to convey to them the benefits of preventive and early visits. USAID's study reveals that those lacking health insurance refrain from contacting public health facilities because of the high (formal and

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<sup>11</sup> The employed, self-employed, unpaid family workers, and other economically active people.

<sup>12</sup> Beneficiaries of the Social Insurance Institute, social assistance (NE Program) or disability payments, people registered as unemployed jobseekers with the National Employment Service, foreign asylum seekers in the country, children under 18, students under 25 with no incomes from business activities, among others.

<sup>13</sup> World Bank-EBRD Life in Transition Survey, cited in World Bank 2014.

informal) costs,<sup>14</sup> while others access care through emergency rooms or pharmacists. The study also revealed incidences of the poor borrowing money to cover their health care needs.

**2.29 *Even for the insured there are barriers.*** Some with insurance, who cannot afford extra payments, indicate that they are subjected to unequal treatment, must wait in line for hours (especially at hospitals) and settle for lower quality service. Corroborated by interviews and field visits, the USAID study also reveals limited access to drugs for the insured, as HII puts caps on drug expenditures, which (according to interviews) constrain access to full treatment for more expensive protocols (e.g., cancer treatment). While laboratory services are available through insurance in urban centers, patients of rural centers with no such services who are referred to urban centers do not receive coverage. Overall, State spending on health is estimated at about \$360 million annually and OOP spending is estimated at an additional \$360 million.<sup>15</sup>

**2.30 *Use of Services. World Bank secondary analysis of LSMS data reveals that between 2008 and 2012: (a) use of outpatient care was lower among the poor; (b) it has decreased for all five quintiles of per capita consumption; and (c) gaps between the rich and the poor's use of outpatient care have increased (World Bank 2014).*** HII pays a 10 percent bonus to primary health facilities for achieving a certain threshold of primary health care visits. Providers, HII officials and MoH officials, both central and regional level, have noted their sense that the number of visits have increased. But IEG was unsuccessful in accessing statistics and trends from HII, MoH/PHC Directorate or providers. The ICR provides trends in the number of visits to PHC doctors between 2008 and 2011, showing improvements both in first-time patient visits (from 696,147 to 1,077,681) and in total number of visits (from 4,149,351 to 5,754,452). Using the WDI estimate for the 2011 population (3.15 million), this would translate into about 1.8 visits per capita in 2011, slightly lower than the target of 2.0 (and the estimate of 2.04 provided in the ICR).<sup>16</sup> Interviews corroborated by USAID's consumer study indicate that a number of visits do not involve an examination by the PHC physician. Rather, they are just to seek the paperwork permitting the insured to purchase drugs or see a specialist. A PHC center in Durres reported more first-time visits from chronic patients and from women over 35 for breast cancer screening, incited by HII bonuses for these visits. Several PHC centers noted difficulties in getting pregnant women to visit centers, as some are not aware that these services are free and others (who can afford it) prefer to visit private or referral services, equipped with a sonogram. The ICR reports that immunization of children remained consistently high (94 percent in 2010, 95 percent in 2012).

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<sup>14</sup> This phenomenon is corroborated by World Bank secondary analysis of LSMS data showing increasing OOP for higher expenditure quintiles and decreasing OOP for lower quintiles and attributing this to self-rationing by the poor.

<sup>15</sup> These estimates were provided by the Project Director and corroborated by the World Bank, which (a) reports Government health spending of \$332 million for 2012, \$335 million for 2013 (plan) and \$340 million for 2014 (draft); and (b) notes that about half of total health private and public spending is made up of out-of-pocket expenditures (World Bank 2014).

<sup>16</sup> The ICR does not cite the source of the data presented.

**2.31 Quality of Primary Health Care Services.** The project's support to quality improvements included the training of 631 primary health physicians from three regions (Tirana, Elbasan, Durres) versus the six region originally planned, scaling up the family medicine training initiated by USAID in six regions and complemented with a quality improvement training component. The project also financed the preparation of five new evidence-based clinical practice guidelines (CPGs)<sup>17</sup> against a target of six. Conflicting information from key informants make it difficult to confirm whether or not these protocols were ever distributed in hard copy to all PHC facilities/physicians, as planned, or whether they were only disseminated electronically. Training provided under the project included coverage of CPG implementation.

2.32 The bonus payment system developed in support of PDO#2 (see para. 2.39) is likely to have incited providers to improve services linked to key performance indicators, including: monitoring and ensuring a healthy range of blood pressure and glucose levels of, respectively, hypertensive and diabetic patients. The project supported the establishment of a licensing and accreditation function within the NCQSA, but only one PHC center (urban Tirana) has been accredited to date, and this was on a pilot basis. The accreditation process took four years (including a self-evaluation and an independent evaluation). The project's quality grant, designed to finance proposals from PHC providers to improve quality, was dropped, because of Government's lack of interest. The project's support to a Continuing Medical Education (CME) center was dropped as the Swiss provided the bulk of needed support.

**2.33 Improvements to PHC service quality were not systematically tracked, but appear to be modest.** IEG field visits found mixed evidence of the availability and use of CPGs in PHC facilities. There is no information on who attended training, what was learned, no proof of increased knowledge and capacity as a result of training, and no follow-up pedagogical support or accountabilities linked to CPG use. Deficiencies in infrastructure, equipment, furniture, drugs and other consumables, noted to have undermined physical access, also depress service quality. While only one of the 421 PHC centers has been accredited to date, the accreditation process for PHC Center #4 was instrumental in improving attention to service quality. Other centers visited expressed their intention to seek accreditation. Interviews with a range of MoH and HII officials and service providers were almost unanimous in noting that poor quality remains a critical issue, as indicated by: inadequate physician time with patients (due to excessive and duplicative reporting requirements, and their involvement in the private sector), inadequate financing of essentials, especially drugs. Consumers were also vocal in expressing their concerns about quality, highlighting: corruption, poor service, lack of hygiene, lack of medicine and incompetence of some providers, and even worse service in the absence of informal payments. A World Bank-

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<sup>17</sup> National Clinical Best Practice Guidelines were produced for: (1) General Patient Management within PHC (including adult asthma, upper respiratory infections, urticarial and angioedema, acute diarrhea, anemia, sexually transmitted infections and adult pneumonia); (2) Anemia Management in Patients with Chronic Renal Insufficiency; (3) Treatment of Persons with Type 2 Diabetes; (4) Management of Arterial Hypertension in PHC; (5) Cerebral Vascular Accidents. Priority areas of child health and antenatal care, identified at the project's outset, were not covered by these five CPGs.

EBRD Life in Transition Survey II reveals that more than half (55 percent) of Albanians are dissatisfied with the quality and efficiency of public health services.<sup>18</sup>

**2.34 Unnecessary use of Secondary and Tertiary Care.** HII's policy of reimbursing the costs of hospital services only if the insured patient has first been seen, and referred by, the PHC physician was designed expressly to discourage the inefficient, unnecessary use of these services. The project supported the design and implementation of this policy (under PDO 2) and its dissemination to the public.

**2.35 Available evidence indicates continued unnecessary use of hospitals.** While MoH and HII have not systematically tracked trends on this front, qualitative evidence is consistent and compelling. Despite the population's general knowledge of HII's policy and procedures to access services through the referral system (USAID, 2013), virtually all respondents and IEG's own observations indicate persistently inefficient use of hospitals and specialists. Tirana University Hospital and Durres Regional Hospital are filled with patients who bypass primary care providers, including: (a) the uninsured, who frequent emergency rooms;<sup>19</sup> and (b) the insured, who can afford to pay for these services, themselves, and choose to avoid the excessive bureaucracy and waiting time involved in getting a referral, which would allow them reimbursement of hospital fees. Both the USAID consumer study and direct observations and exchanges with hospital officials in Tirana and Durres reveal that a third group – those who are insured and follow the proper channels for referral services – are largely those who cannot afford to pay for hospital services themselves. They face longer lines, generally more difficult access and (in their perception) lower quality services than those who bypass the referral system and pay for hospital care directly. The unnecessary use of hospital facilities, also documented in World Bank 2014, is prompted largely by a lack of confidence in the quality of care at the primary level, as well as improvements in roads, which make more sophisticated care (in hospitals and private sector) increasingly accessible. Consumers report that PHC facilities are frequently perceived and used as offices that provide signatures for referrals, with some family doctors only contacted after a specialist visit to fill in forms. OOP expenditures for outpatient services provided at hospitals amount to around 28 percent of total OOP spending, suggesting that a considerable proportion of outpatient care is being sought at the hospital level, instead of at PHC facilities (World Bank 2014).

**2.36 Secondary and Tertiary-Level Hospital Equipment.** The project, as restructured in April 2010, procured equipment for regional hospitals providing secondary referral services, as well as for tertiary-level Tirana University Hospital. The rationale for this additional equipment was to strengthen the primary-secondary care interface. Mammography equipment was purchased to support breast cancer diagnosis in four main hospitals (two urban, two in the mountains) and autoclaves were purchased for seven main hospitals to improve treatment of hospital waste, heretofore incinerated. Specialized equipment was also provided to Tirana University Hospital's pediatric surgery department and to its cardiology

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<sup>18</sup> Cited in World Bank 2014.

<sup>19</sup> Some 70-80 percent of all emergency room visits to the Durres Regional Hospital are estimated to be for primary care. (Interview with Director of Durres Hospital)



department, bringing (according to some informants) this department to European standards. Medical equipment provided to the 12 regional hospitals was intended to support implementation of the hospital rationalization plan (paras. 2.53-2.54).

**2.37** *Even though the rationale for the purchase of this equipment was to improve the link between primary and hospital level referral services, this equipment's contribution to the general objective of improving PHC access, quality and utilization is estimated to be marginal.* This equipment was installed and reported to be functional by the end of the project. But there was no tracking to assess improvements to hospital capacity, linked to these specific investments. Many informants expressed appreciation for this equipment, while others expressed their misgivings. Even if mammography equipment is used at full capacity, some have noted that the lack of a holistic approach to cancer control and treatment raises the risk of inadequate treatment capacity for the expected increase in new cases. Yet others note that improved diagnostic capacity is an important first step. Some training was included in the procurement package, but there is concern about, and little tracking of, the proper use of equipment. And maintenance systems for hospital equipment are severely lacking. IEG's visit to Tirana University Hospital revealed that, while warranties had not yet run out and maintenance contracts beyond the warranty periods had been purchased, general maintenance systems and practices at the Hospital give cause for concern. Contract awards for equipment maintenance are neither fully transparent nor given to the most qualified contractor (e.g., an information technology expert versus a mechanical engineer). Lack of spare parts, budget and skills for maintenance of sophisticated equipment has caused some equipment to be no longer in use. The mammograph and angiograph equipment purchased by the project for Tirana University Hospital were reported to be the only ones in the entire hospital that were said to be functioning, indicative of maintenance deficiencies. The new Minister of Health impressed upon IEG the need to track the proper use and maintenance of hospital equipment.

**PDO #2: Improve the Recipient's capacity to formulate and implement health policies and reforms in the health sector. – Substantially Achieved**

**2.38** *A package of World Bank support, composed of analytic work, development policy lending and implementation support under this project, has contributed to strengthening of MoH and HII capacity in the formulation of well-conceived health financing policy.* In keeping with the recommendations of the Bank's 2006 Health Policy Note, a number of policy decisions were made in the early years of the project: (1) in 2006 HII assumed responsibility for financing all PHC offered through public facilities (but this financing was limited to physicians' salaries and reimbursement of pharmacists with HII contracts); (2) in 2007 the HII financed all costs of primary health care provided to those covered by insurance through new performance contracts, calculated on a capitation basis and including performance bonuses; and (3) in 2009 Government made the decision to unify resources for health under one single purchasing agency, HII, which meant that HII would also be responsible for purchasing hospital services through performance contracts. Another major reform introduced during the life of the project was the new "Law on Compulsory Health

Care Insurance,” approved by Parliament in February 2011.<sup>20</sup> The project supported this effort by financing technical assistance to MoH and HII in the drafting, review and revision of this law. This assistance helped strengthen the capacity of MoH and HII in the formulation of health insurance policy and provided expert quality assurance and oversight to ensure its internal coherence and coherence with other reforms. Nevertheless, it is difficult to assess whether these policy decisions would have been made, or at least delayed, in the absence of Bank support. Interviews indicate the value added of the Bank’s technical input to these decisions. But Government’s internal policy-making process and other technical support are also likely factors.

**2.39 Overall, implementation of health financing reform at the primary care level was successful.** The project provided substantial technical assistance and support to HII and MoH in the design and implementation of *performance contracts for primary health care*. Technical assistance was provided under the PHRD grant (US\$400,000) to help HII develop appropriate payment and contracting methods and to build the capacity of HII (central, regional and district levels) and PHC providers/facilities to implement this reform. 2014 marks the seventh year that performance-based contracting is being implemented in Albania in all 421 public PHC facilities and in pharmacies serving PHC patients. The PHC provider payment mechanism is characterized as a hybrid model (World Bank 2014). Eighty percent of PHC facilities funding is based on the historical budget. Funding also includes a 10 percent bonus for level of activity (reaching a threshold of number of visits) and a 10 percent bonus for focusing on critical services, among which are proper monitoring and management of hypertensive and diabetic patients. Doctors’ salaries are based on capitation, skills, experience, seniority of physicians and geographic posting. The productivity bonus is awarded on a monthly basis, while the quality bonus is awarded on a quarterly basis. The PHC physician decides on their distribution and use, which can be passed on to other staff and/or used for supplementing the budget for drugs, consumables and other recurrent expenditures. Limited autonomy of the PHC does not allow use of the recurrent expenditure budget for other needs (e.g. minor repairs of infrastructure). PHC centers are allowed to retain fees collected from the uninsured to invest in furniture, equipment and other needs. But recent changes in policy now require approval by the Regional Director for Public Health, responsible for infrastructure and investments, before such purchases can be made. There are also issues with affordability of PHC services, with caps placed on the purchase of medicines, which can exceed available financing for more complicated diseases, such as cancer. The project also supported the establishment of systems and controls underpinning contracts and HII oversight, which appear to be working well.

**2.40 Implementation of health financing reform at the hospital level has fallen short of expectations.** With the 2009 decision to make HII sole purchaser, HII central and regional offices created departments for hospital performance contracting. The project financed technical assistance in 2009 to advise HII on the definitions and principles of performance analysis and on specific actions it could take to develop hospital performance analysis capacity to manage its health care purchasing. The work plan proposed through this

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<sup>20</sup> Approval of this Law by Parliament was among the Government Prior Actions that were conditions for the release of funds under the one-tranche Social Sector Development Policy Loan, which became effective on August 25, 2011.

technical assistance was not pursued. The project financed additional technical assistance in early 2012, which laid out recommendations and strategies for incremental reform of hospital payment in Albania. Recommendations center around: hospital governance and management; quality assurance (especially accreditation of hospitals); information management (covering performance and cost data); and changes to the funding model.<sup>21</sup> With USAID support, this same consultant prepared (with the HII/MoH Technical Commission) another building block for the costing and financing of hospital care. Published in September 2013 (9 months after HSMP closed), this work, building on the hospital rationalization study (PDO# 3), defined the package of hospital services (tertiary, secondary and small municipal/district hospitals) and provided cost data.

2.41 All of this support notwithstanding, to date full implementation of hospital financing through performance contracts has been limited to the Durres Hospital (supported by USAID and others), because of its pilot status. While HII does have the responsibility for financing all hospitals and performance contracts have been signed as of 2011 (a prior action under the Social Sector DPL, para. 3.35), in actual fact, the budgets of all hospitals except for Durres are established by MoH and approved by the Council of Ministers based on historical budgets. Because these hospitals do not have a Bank account, their budget funds are held by Treasury and released to hospitals based on receipts for expenditures, not on performance. In contrast with the PHC performance contracting system, HII has very few funds – and leverage – to oversee and enforce performance contracting at the hospital level. The above-listed recommendations for implementing hospital financing reform constitute a critical path for moving forward.

2.42 *The development of information systems for HII for prescription drug processing, patient registration/enrolment and service monitoring was only partially achieved.* In short, only the hardware was ultimately purchased and put into place. Acquisition of the software was delayed due to HII failure to take decisions affecting the design of the whole health insurance information system. This is despite the fact that the project did finance technical assistance to assess needs and propose the design of the system. Delays in decision-making caused the project to drop the software procurement in its 2011 restructuring. The Austrian Government had initially agreed to support the acquisition of this software, but then later withdrew. This is now programmed under a follow-on World Bank project slated for late 2014 approval. The project purchased and distributed computers and printers to 419 primary health centers and servers for regional health directorates to consolidate information from primary health centers. HII central and regional levels and providers report the use of these computers for registering people with the HII and enrolling them with a primary physician. Interviews and direct observation indicate that there is still work to do to fully consolidate information (ensure quality of information, remove duplications, etc.) on patient registration and enrollment. The incentive is high to enroll patients, given that this data provides the basis for physicians' salaries (a function of capitation). The Government had decided to allocate space on a national identity card for health insurance registration, enrollment and key related numbers and patient data. But this

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<sup>21</sup> This technical assistance and a hospital rationalization study and master plan (paras. 2.53 and 2.54) will be key inputs to the development and implementation of a new World Bank-financed health project, currently under preparation.

has not yet been implemented. Some informants questioned the wisdom of: procuring hardware before the design and acquisition of software; the allocation of a computer to almost every physician, especially in areas with no internet and no maintenance capacity; and the use of an electronic card for health/health insurance, given lack of reliable electricity supply in some centers.

2.43 ***The creation of a functional public health data warehouse in the Institute of Public Health (IPH) was not achieved.*** In this case, too, the project financed only hardware, along with servers and licenses. The software necessary to get the system running has yet to be developed and remains a priority for the IPH.

2.44 ***The project's investments in strengthening MoH capacity for strategic sector management provided some important building blocks, but fell short of expectations, largely due to staff turnover and slow uptake of technical assistance.***

2.45 At the request of the MoH, the project financed a WHO-recruited expert to update its health sector strategy. The work was undertaken through working groups for an inclusive, consultative process and culminated in the production of "Health System Strategy 2007-2013." Informants provided conflicting information about whether or not this strategy was ever approved by Government. By all accounts, and in IEG's own assessment, the technical assistance financed under the project to develop a viable M&E system was of high quality. Undertaken jointly with the M&E Core Working Group and approved by the M&E Reference Group,<sup>22</sup> the document produced through this process: outlines the framework for M&E, based on the above-cited health system strategy; lays out the organizational structure, processes and outputs of the system; proposes a streamlined set of annual health system performance indicators (both outcome and impact) for measuring health system performance; outlines how these indicators should be used to underpin annual health sector reviews in order to inform strategic planning and evidence-based policy; and summarizes the transition plan, training needs and resource requirements to implement the M&E system. MoH adopted the recommendation to establish a Monitoring and Evaluation Sector within its structure, reporting to the Director of Policy and Planning. But staff turnover has undermined its functioning.

2.46 Annual performance reviews were envisaged under the project, as specified in the Financing Agreement, the first one expected to be undertaken by end-October 2006. In actual fact, the first annual performance report was issued and discussed only in 2011, followed by the second one in 2012. These reports included information on some of the milestones and performance indicators (60 of some 140) proposed in the above-cited M&E framework. But the quality of the reporting (data and analysis) is noted by a number of informants to be lacking. USAID is supporting continued assistance to M&E capacity building under its ongoing project, including the financing of the consultant who initiated this work under HSMP. IEG's attempt to exploit these reports for the purposes of this evaluation

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<sup>22</sup> Both Groups were established to develop the M&E Reference Document and were intended to serve as the institutional structure for maintaining the M&E process and a platform for coordinating the activities of the international partners.

was unsuccessful. A quick look revealed that trends/data were not available to report on project-specific indicators or other relevant ones to measure progress against HSMP objectives. Moreover, the M&E Head had just vacated that post with the changes in Government and could not be contacted for a meeting. No source of information (documents, interviews, field visits) provided indication of the tracking of M&E indicators or of the analysis and use of local-level data for performance assessment and decision-making.

2.47 The project supported a National Health Accounts exercise compiling accounts for three consecutive years: 2007-09. This involved training, data analysis attempts to develop and institutionalize NHA and support to the Department of Financial Planning. The work was supervised by a Steering Committee lead by MoH and including representatives from Ministry of Finance, HII and the Institute of National Statistics. The exercise applied a new methodology, which collected comprehensive information and linked different components of this information together for enhanced analysis. The exercise culminated in: a database as a platform for discussion and analysis; a functional classification of health expenditures adding new information for health policy and budget planning; regional health expenditure estimates informing planning and making possible regional comparisons of productivity; and updated information of the mix of public and private expenditures.<sup>23</sup> While this proved to be a useful and informative product, the support did not succeed in institutionalizing the NHA function within MoH. Additional technical assistance is needed to improve capacity in order for MoH to carry out this exercise on its own in the future.

2.48 ***Important progress was made in strengthening the capacity of the National Center for Quality, Safety and Accreditation of Health Care Institutions (NCQSA) to strengthen its quality assurance and oversight functions. But there is a large unfinished agenda for quality assurance and oversight.*** The project provided technical assistance and support to the fulfillment of each of three functions of the NCQSA. *First*, it supported the process of developing *clinical practice guidelines* (CPGs) and related training. When NCQSA was first established, one year before the project start, there were no CPGs, only a few papers from pharmaceutical companies and projects, and no structure within MoH responsible for developing them. With MoH approval and in collaboration with an inter-institutional team (MoH, HII, NCQSA, and other relevant health professionals), the project supported NCQSA's new model for developing CPGs: involving HII and patients, as well as health providers in the design; following an evidence-based approach; abandoning links to pharmaceutical companies' protocols to avoid conflict of interest; and limiting guidelines to what is feasible to implement within the Albanian health system. This process was used for developing the five CPGs supported under this project, as well as for numerous other guidelines also developed by NCQSA. Adherence to these guidelines is reported to be weak to date and with no follow-up oversight or accountabilities.

2.49 *Second*, the project supported the *licensing and accreditation function*. NCQSA developed standards for accreditation of five categories of health services: hospitals, primary

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<sup>23</sup> The Albanian share of GDP devoted to public health care expenditures is the lowest share in Europe, together with Cyprus. The public private mix of total expenditures is 50%/47%, with the remaining 3 percent financed by foreign programs.

health care, dentistry, pharmacies and laboratories.<sup>24</sup> This was done through working groups including representatives from MoH, HII and patients organizations. Standards needed to be measurable and achievable. The accreditation process involved instruments and processes for self-evaluation and, subsequently, external evaluation. Project support also included training of 160 people<sup>25</sup> in 6 regions in quality indicators and accreditation processes. Trainees became part of a network of quality coordinators. Under a pilot phase three facilities have been accredited: Durres Regional Hospital, PHC Center #4 in Tirana, one laboratory, one dental practice and one pharmacy. Both Durres Hospital and PHC Center #4 managers spontaneously mentioned to IEG the accreditation process and its positive effect on quality awareness and quality improvements. Under the health care law accreditation of health facilities will move from a voluntary to a mandatory process.

2.50 *Third*, the project financed technical assistance for *health technology assessment*. Undertaken over the period 2009-2011, this work involved: (1) an evaluation of the current situation of health technologies in Albania and proposals for enhancing health technology and its proper use and maintenance; (2) an assessment of current capacity for health technology assessment and proposals for its further development; (3) the development of a strategy for the institutionalization of health technology assessment and evidence-based medicine; and (4) training in evidence-based medicine. While a knowledge center was established, as recommended, it is not clear what other recommendations have been implemented and what permanent capacities and functions have been established.

2.51 While NCQSA is currently charged with these three functions, the appropriation and institutionalization of a quality culture needs to happen throughout the health system, including: MoH, HII, service providers, and the population. One mission of NCQSA not supported under the project is the “democratization of the health sector,” meaning the establishment of partnerships with civil society and consumers for managing their own health, for collaborating with the health system in monitoring quality and performance and for keeping the health system accountable to the people. This was included among the priorities listed in the 2006 Health Policy Note (para 1.13).

### **PDO #3: Improve hospital governance and management. – Modestly Achieved**

2.52 *Project support appears to have had little impact on hospital management and financial management.* The project supported the training of 180 hospital managers and financial staff (9 groups of 20 trainees each), exceeding the target of 150. Delivered by 12 Albanian trainers, this training aimed to improve management skills and awareness of modern management concepts. The project did not develop and introduce accounting and internal control structures for hospital care providers, as planned. Considerable turnover of staff trained was one important factor in failure to substantially improve management. The appointment of unqualified hospital directors for political reasons was another.

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<sup>24</sup> According to the head of NCQSA, Albania is the first in Europe to have done this for all five categories of services.

<sup>25</sup> Participants included: facility directors, economists, clinical nursing and quality managers from hospitals and PHC centers and GPs and staff from regional public health institutes.

**2.53 *The project financed technical assistance to support the development of a model and regulatory framework, including by-laws and regulations, to support the move of MoH hospitals to the status of autonomous public entities.*** The bylaws for hospital autonomy were discussed within MoH. The project also financed evaluations of the Durres Hospital and the TRHA pilots. A hospital rationalization study was also supported, which: assessed some efficiency aspects of all hospitals in Albania individually and collectively (low bed occupancy, services, costs); explored several options for rationalizing the hospital sector; recommended the best option based on quality and cost-effectiveness criteria (strengthening of 12 regional hospitals and reconfiguration of some 30 district hospitals); and proposed a master plan for implementation and arrangements for its monitoring and evaluation. The implementation plan included: building regional referral networks; defining in partnership with HII the package of services to be delivered by each level of hospital care, based on Albanian standards; reshaping the role of several district hospitals as ambulatory care centers; and informing the public of these changes.

**2.54 *The hospital rationalization study was issued in final in 2008, but little action was taken in favor of its implementation.*** Pilots in two regions to reconfigure existing facilities (one regional hospital and two district/municipal hospitals transformed into ambulatory centers) under one administrative structure were envisaged. Four years later, in June 2012, the project financed another technical assistance by a different consulting firm, which proposed a design, tools and action plan for implementing the hospital rationalization plan. It identified two pilot hospitals: Lushnja District Hospital and Vlora Regional Hospital. There is no evidence that any further action to implement the plan, including the pilots, has been taken. With USAID technical assistance, in collaboration with a Technical Commission assigned to establish a Package of Inpatient Services for Hospitals, a package of services has been defined for district, regional and tertiary hospitals and is proposed for adoption (USAID, September 26, 2013). Added during the 2010 project restructuring, the project provided technical assistance to MoH on the privatization of all non-medical activities in regional hospitals. The existing outsourced non-medical services were analyzed at Tirana U Hospital and a framework for outsourcing services was developed based on these findings which can be applied to support MoH in the tendering process. Outsourcing has been done in 3-4 hospitals, using guidelines generated by this assistance.

**2.55 *The project envisaged foreign and local technical assistance to test the model developed for hospital autonomy in selected hospitals. This was not implemented under the project.*** Nevertheless, USAID is currently supporting the piloting of autonomous hospital management, as laid out in the project-financed technical assistance, in three hospitals: Mother Geraldine Obstetric/Gynecological Hospital in Tirana; Korca Regional Hospital; and Leisha Regional Hospital. A key strategy articulated through the technical assistance and carried through to USAID's pilots is not to grant autonomy to all hospitals regardless of their management capacity, but rather to grant autonomy incrementally to hospitals with solid management capacity. WHO chairs a working group on hospital management performance contracts (Leisha, Korca, Tirana) with eventual plans for nationwide expansion.

**2.56 *A wide range of informants were consistent in noting persistent, important deficiencies in the management and financial management of hospitals.*** A recent USAID

study's list of preliminary requirements for moving ahead with global budgeting for hospitals is illustrative of persistent issues of weak hospital management, most notably: weak governance of hospitals; lack of skilled hospital management; lack of continuity of hospital management; and weak performance measures, accountability and transparency, which undermines control of corruption.

#### **D. Efficiency -- Modest**

**2.57 *Initial and end-of-project cost-benefit analyses were undertaken, but their assessment of benefits cannot be verified because of a lack of viable data. The likelihood of even the lowest case scenario benefits stream being achieved is uncertain, in light of the partial evidence and analysis of efficacy in Section C. of this Chapter.*** Due to difficulties in assessing Components 1 and 3, both the design stage and end-of-project analyses focused on Component 2 Improving Primary Health Care Delivery, covering about 50 percent of total estimated project costs and 60 percent of actual costs. Improved PHC services were expected to culminate in two direct benefits (reduction in unnecessary hospital admissions and reduction in unnecessary referrals to specialist care) and in additional indirect benefits (reduction in OOP travel costs to hospitals and specialist clinics, averted productivity losses, and reduced mortality). The initial cost-benefit analysis was estimated on the basis of total project costs, assuming benefits due to reduced mortality, reduced hospital bed-days, lower travel costs, and savings in foregone earnings to the society. The scenario deemed at the design stage most likely to materialize assumed that benefits would start materializing in Year 4 and yielded a net present value of \$973,013 and a 9 percent economic rate of return over 20 years, using a 10 percent discount rate.

**2.58** Using only the cost of Component B and exploring the same expected benefits, the end-of-project cost-benefit analysis base case scenario yielded a net present value of US\$6.2 million, a benefit/cost ratio of 1.45 and an 18 percent economic rate of return, using an 8 percent discount rate. Sensitivity analysis under alternative scenarios (at 8 percent discount rate) showing lesser impacts of the intervention yielded economic rates of return ranging from 7 percent to 14 percent, and benefit/cost ratios ranging from 0.96 to 1.25. However, even the most modest end-of-project scenario (3 percent per annum decrease in hospital admissions and in specialist referrals; and 2 percent per annum decrease in mortality) cannot be verified for lack of data. Available evidence presented in the efficacy section reveals continued unnecessary use of hospitals and specialist services; and the ICR corroborates IEG's findings that there is no strong evidence to suggest improved health outcomes for defined health conditions (Annex E, Table E-2).

**2.59 *The project was not implemented efficiently.*** At US\$19.0 million, the final project cost was almost exactly what was estimated at appraisal, but the implementation period was almost six years versus the four years originally anticipated, and the objectives were not fully achieved. Furthermore, project restructuring caused the project resources to be used less optimally. Turmoil around the political elections, especially in 2009, and substantial turnover of Ministers, high-level officials and experienced staff in health institutions, and hospital managers all caused important delays. Failure to establish thematic technical working groups also delayed implementation. Technical assistance was not fully exploited because counterparts were not appointed – in time or at all. The investment in the health



information system was inefficient, reduced only to hardware investments and neglecting software because of failure on the part of HII to make critical decisions affecting system design. The lack of clear roles, responsibilities and accountabilities of health institutions – at central, regional and district levels – also contributed to inefficiencies in implementation.

## E. Other Ratings

2.60 **The project's Outcome rating is Moderately Unsatisfactory.**<sup>26</sup> The project's objectives are highly relevant to current country conditions, national strategy and priorities for the sector and the Bank's current CPS, as well as the Bank's Health, Nutrition and Population Strategy. The design relevance is modest, overall. The results chain in the original design was largely supportive of the achievement of project objectives. However, some critical activities were excluded (addressing informal payments, clarification of roles, responsibilities, accountabilities of key health institutions and their inter-relations, among others). The two project restructurings further weakened the project results chain, adding a number of investments not directly supporting the project objectives (hospital equipment) and deleting others that were critical to these objectives (quality grant facility, HIS software, among others – para 2.7). The objective to improve access, quality and use of PHC services and to decrease unnecessary use of hospitals was modestly achieved. The project was successful overall in achieving the objective to improve capacity to formulate and implement health policies and reforms, especially with regard to new provider payment methods for PHC, based on capitation and bonuses. The objective of improving hospital governance and management was modestly achieved. Project efficiency is modest because implementation was inefficient, and not all objectives were achieved, even though the costs estimated at appraisal were fully incurred.

2.61 **Risk to Development Outcome is Rated Significant.**

2.62 **Political risk is moderate.** The new Government has expressed that health is a priority. Indeed, its election platform rested upon a strong commitment to universal health coverage financed by the State. This vision for health is underpinned by the policies and reforms supported under the health project, including: HII as the sole purchaser of services; financing based, in part, on capitation and performance contracts; enhanced sector stewardship; and hospital autonomy.

2.63 **However, financial risk is significant.** The health sector is severely underfinanced. Government health spending has been quite stable over the past several years (2005-2011) at

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<sup>26</sup> There is a marked difference between this PPAR's rating of the project's outcome and IEG's satisfactory rating of the project's outcome based on its 2013 desk review of the Region's Implementation Completion and Results Report. This PPAR downgraded IEG's initial ratings of: (i) design from substantial to modest based on weaknesses detected in the results chain, which became more evident in this in-depth analysis; (ii) efficacy of the first objective from substantial to modest based on the paucity and unreliability of relevant data and trends, and on the availability of new evidence since the ICR was produced; and (iii) efficiency from substantial to modest because the pre- and post-project economic analyses was based largely on expected benefits, whose achievements could not be verified.

just below 3 percent of GDP, lower than any other Eastern European country;<sup>27</sup> and OOP expenditures remain high, relative to other countries in the sub-region, at slightly over 3 percent of GDP during this same period (World Bank 2013a). While the Prime Minister has committed to raise the share to more than 3 percent over the next few years, this is still much lower than other countries in the region, and expanded public allocations and spending may not materialize in the absence of improvements in the country's tight fiscal situation. Adding to the financial risk is the substantial debt incurred by the health sector, estimated at \$50-\$60 million, of which 70 percent for hospitals (mostly Tirana University Hospital, and mostly for debts owed to drug companies). This debt seriously undermines prospects for maintaining and enhancing achievements.

2.64 ***Institutional risk is significant.*** The new Government has appointed health sector leaders (Minister of Health, two Deputy Ministers of Health, and the head of the HII) who are well qualified for the jobs and poised to make important contributions to continued progress in health sector reforms and outcomes supported under the project. But there are institutional risks. Excessive turnover of experienced staff and appointment of unqualified staff has been the norm throughout the life of the project. The abandonment of this practice and the appointment and retention of well-qualified staff will be critical. Institutional risk will also remain high unless and until there is a clarification of roles, responsibilities and accountabilities of all key health institutions, most especially, MoH, HII, NQAA,<sup>28</sup> IPH, at central, regional and district levels.

2.65 ***Technical risk is moderate.*** The project provided substantial, high quality technical assistance to support a range of health sector reforms. But evidence indicates that Government's uptake of this assistance was modest. The new Government, with World Bank's encouragement, has read all of the technical assistance reports, acknowledged its quality and relevance, and expressed its intention to use them in continuing health sector reform. Development partners have also noted the quality and relevance of this work and its application in their ongoing work. There is less certainty that the excellent work on quality, especially the accreditation process and the preparation of CPGs, will be fully exploited and continued. It is not clear whether there is sufficient budget and commitment to move decisively towards mandatory accreditation of all health establishments (as articulated in the Health Care law) or to undertake the supervisory and pedagogical work to inspect and ensure adherence to service standards and protocols. A number of respondents also noted their concern that faculty at Tirana University Hospital do not want to be held accountable for applying CPGs and service standards.

2.66 ***Governance risk is significant.*** The likelihood of sustaining and improving project outcomes rests in part on the will and ability to fight corruption in the sector. The new Government is committed to addressing corruption in the pharmaceutical sector. The

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<sup>27</sup> Romania allocates 6 percent of its GDP to health.

<sup>28</sup> NQSA is playing a fundamental role in quality assurance (accreditation of health establishments, preparation of CPGs, Health Technology Assessment, partnerships with consumers). But a culture of quality does not seem to be sufficiently institutionalized within MoH, responsible for sector stewardship. This is reflected in the absence of an institutional home for quality within MoH and in the absence of an appropriation of a quality culture.

formidable task of reducing/eliminating informal payments (bribes) for services will also require commitment, capacity and resources. This is critical to improving service access, especially for the poor.

2.67 ***Social risk is also significant.*** The population's strong distrust of the health system reflects their perception of poor services and corruption. This is likely to remain the case unless and until the health sector develops reciprocal partnerships with civil society, patient organizations and individual patients for the purposes of designing and delivering health sector reform and preserving and managing their good health.

2.68 **Overall Bank Performance is Moderately Satisfactory.**

2.69 ***Quality at Entry is Rated Moderately Satisfactory. The project design was grounded in the Health Policy Note (World Bank, 2006), which has been noted by a wide range of informants to be of high technical quality and relevant to the challenges and issues the sector was facing.*** Many informants also noted their appreciation of the participatory approach to this sector analysis and to project design, which involved a broad range of Albanian experts and other stakeholders. Health journalists, however, did note that they were not included. The original design laid out a results chain that was supportive of the project objectives, albeit omitting a few facilitating elements. The preparation process was conducted in full consultation with key development partners supporting the sector, especially WHO, USAID and SDC, resulting in good synergies and complementarities in their collective efforts. The sector analysis appears to have informed and influenced Government's national health strategy 2007-2013, which articulated Albania's vision for sector reform. And the project was poised to support the implementation of this reform.

2.70 ***The implementation arrangements appropriately supported the management of this project by a line Department within MoH instead of setting up a parallel project management structure.*** It provided the flexibility for moving towards a sector-wide approach arrangement at the project's mid-point, if sufficient capacity were built. During the mid-term review it was decided that there was insufficient capacity to move ahead on that front. The establishment of three technical working groups was a good approach for encouraging active involvement of key staff in the design, implementation and uptake of technical assistance envisaged under the project. Fiduciary arrangements and staffing were adequate. A shortcoming, however, was the ambitious (four-year) timeframe of the project, which, in retrospect far exceeded MoH capacity to undertake the substantial procurement under the project, particularly with regard to bid evaluation.

2.71 ***The project gave due attention to poverty dimensions of health sector reform,*** acknowledging inequities in financial access to services, and attempting to address these through clear pricing policies and the extension of free health insurance benefits to eligible non-economically active populations.

2.72 ***The risk assessment did anticipate limited implementation capacity and leadership turnover, which came to pass. But, overall, the original design was too complex for implementation in a context of limited capacity.*** Anticipated mitigation measures were employed, although not all were effective. The technical working groups were very slow to

be established and become functional. Annual reviews of sector performance did not happen until five years into the project. The reform of moving to single source purchasing under HII leadership was also an anticipated risk for its impact on MoH and its ability to adapt to its new roles and responsibilities. A strategy to mitigate this risk was not fully developed and MoH (and other health institutions) could indeed have benefited from more clarity and guidance on this front. The move toward increased independence for hospitals and managerial autonomy and accountability was also raised as a risk, although the nature of the risk was not well identified. Indeed, there was very little progress in undertaking this reform, despite the technical assistance which laid out the path and the very successful experience with the Durres Regional hospital. Mitigation measures proposed (legislation in place, advocacy on the need for reform, involvement of stakeholders in the initial stages) were not fully realized.

**2.73 Quality of Supervision is rated Moderately Satisfactory. *The Bank's supervision missions were sufficiently frequent, averaging between two and three a year during the life of the project.*** Aide-memoires were thorough, representing a broad-based, systematic supervision exercise and dialogue, each one providing an overview of progress by component, raising issues undermining smooth implementation, and recommending actions to improve both implementation and results. The Aide-memoires also tried to focus on development objectives, but their tracking was made difficult with the lack of data to track key indicators. The team made a formidable effort, not always successful, to encourage government to work through technical groups and appoint counterparts to technical assistants to ensure the quality and relevance of the work and its appropriation and use for reform implementation.

**2.74** The mid-term review (MTR), held in late 2008, involved a workshop with key stakeholders. It was candid in raising concern about slow implementation and low disbursement and proactive in discussing and agreeing with Government an action plan to accelerate disbursements and implementation. However, Bank management's concern about the low disbursement rate at the time of the MTR (8 percent) led to the addition of large packages of hospital equipment. As noted in paras. 2.36 and 2.37, this equipment did not contribute directly to PDO#1 (improved access, quality, use of PHC services and reduced unnecessary use of hospital services). And it did not contribute to PDO#3 (improved hospital governance and management). In retrospect, the purchase of hospital equipment might have been used to leverage and support the piloting of the hospital rationalization plan, as envisaged under the project, which remains unimplemented.

**2.75 *Supervision of fiduciary aspects was also thorough.*** Bank staff worked closely with Government to explain the Bank guidelines and requirements for procurement of goods and works, selection of consultants, and financial management and reporting under the project. The one mis-procurement issue was well-handled. The Bank invested considerable staff time (including the involvement of the Regional Vice President, Country Director and Country management) to discuss this issue and, exceptionally, granted two extensions providing the opportunity for MoH to reverse its decision. But in the end, the Minister of Health insisted on maintaining their procurement decision in line with the Albanian Procurement Law, thus precipitating the Bank's declaration of mis-procurement.

2.76 ***The quality of the Bank's team has been widely acclaimed.*** There is great appreciation of the technical competence of the Bank's missions (from project identification to project completion), their consultative and collegial mode of work, and the continuity of dialogue and support. Special appreciation of the field-based Task Team Leader (TTL) was expressed by many for her commitment and availability. Before she became TTL, she was a member of the team from the outset, providing continuity over the full seven years, and she continues in this capacity, leading the development of a follow-on health operation. Good coordination and collaboration with key development partners continued during supervision.

2.77 ***Over and above work on the follow-on health operation, the Bank was very supportive and proactive in ensuring adequate transition arrangements.*** In particular, very soon after the new Government was established in September 2013, the Bank's team prepared and discussed a health sector policy brief to open up a productive and supportive dialogue. Moreover, the team encouraged the incoming Minister and his new high-level team to read the numerous relevant technical assistance reports produced under the project as input and support to their vision for sector development. Interviews and other secondary evidence revealed that these technical inputs are likely to be effectively used.

2.78 **Overall Borrower Performance is Moderately Unsatisfactory.**

2.79 **Government Performance is Moderately Unsatisfactory.** *Government did honor its commitment to pay the project counterpart funding*, providing US\$2.9 million or 140 percent of the original amount of US\$2.1 million. It complied with all key covenants, albeit late in fulfilling one of them (first submission of annual health sector performance report in 2011, five years after the project start).

2.80 ***Rapid turnover of Ministers (on average one new Minister per year during the project life), consequent rapid turnover of senior and well qualified technical staff, and the appointment of unqualified staff for political reasons***, all reported by a range of informants and documented in Aide-Memoires, ***seriously undermined health sector capacity to implement reforms, institutional memory, and investments in training and capacity building.*** This phenomenon is reported to have even pervaded appointments of hospital directors. Some report that technical capacity in the MoH has declined as a consequence.

2.81 ***Project implementation was very slow.*** The first few years were wrought with delays in setting up the three technical working groups and in appointing counterparts for key technical assistants. Commitment to the reform of hospitals, especially with regard to their autonomous management, including the establishment of Hospital Boards, was not very apparent. Several informants noted that the autonomy and rationalization of hospitals has been discussed for more than two decades, but no action has been taken. This is particularly perplexing, given the well-known, unequivocal success of the Durres Regional Hospital, which has been functioning autonomously – on a pilot basis – for ten years. It is the best performing hospital in the country, fulfilling its functions as a regional hospital, the only one being financed by HII through a performance contract, and the only hospital in the country that is debt free. Likewise, the delays in implementing the hospital rationalization strategy, well-laid out and agreed at the technical level under the project, are indicative of weak

political commitment and/or weak governance.<sup>29</sup> MoH's exhibited no interest or action to implement the grant facility for quality innovations at the PHC level, yet another indicator of a lack of commitment to the quality agenda.

2.82 ***Tensions between MoH and HII centered on their evolving roles and authority*** (HII assuming purchasing responsibilities for all services, and MoH taking on sector stewardship roles). ***This affected project performance.*** These tensions were also palpable at the regional level.

2.83 ***HII was successful in using project assistance to establish, finance and oversee performance contracts with the PHC facilities,*** based on capitation and bonuses. But delays in critical decisions about the health information system resulted in the project's inability to finance the software.

2.84 **Implementing Agency Performance was Moderately Satisfactory.** ***The project implementation unit within MoH carried out well most aspects of project management, including financial management, procurement, reporting and disbursements.*** Financial management performance was satisfactory, and good internal controls were in place, along with arrangements for disbursement, staffing, reporting and auditing. Audits were completed on time and did not highlight any major irregularities. Quarterly financial reports were almost always on time. The financial specialist had the appropriate skills and abilities. Procurement activities followed Bank Guidelines, with the exception of one mis-procurement (para 2.14). Inadequate skills within MoH to prepare and evaluate bids (technical specifications and English language) caused delays.

2.85 Quarterly and annual reports on the project performance were submitted on time. The Bank's team has noted that they were of good quality providing valuable information on progress in implementation. Performance indicators were also reported in progress reports, to the extent that data were available. But poor data availability and reliability and ill-defined indicators not always linked to project objectives undermined the tracking of progress against development objectives.

2.86 **Monitoring and Evaluation was Modest.**

2.87 **M&E Design** was thorough in the original design with baselines, annual targets, data sources, frequency of collection and responsibilities all spelled out. However, attempts to simplify indicators during the restructuring weakened the M&E design (para. 2.8).

2.88 **M&E Implementation** fell short of expectations because of the lack of timely, reliable data and ill-defined indicators (para. 2.17).

2.89 **M&E Utilization.** Even though project M&E did not generate reliable data for decision-making, the performance data developed under the HII scheme for performance based bonuses had a positive effect on the use of data for decision-making. This being said,

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<sup>29</sup> Nevertheless, as noted in para 2.62, Albania's newly elected Government appears to be strongly committed to implementing these reforms.

the use was limited to the financing of bonuses. There was no apparent use of data at district, regional or central levels to assess overall trends or to use them to enhance progress towards the PDOs.

### 3. Social Sector Reform Development Policy Loan

#### A. Objectives, Design and Their Relevance

3.1 **Objectives.**<sup>30</sup> The objective of the Social Sector Reform Development Policy Loan (DPL) was to support policy changes to (i) improve the effectiveness of social safety nets, and (ii) enhance the efficiency and equity of health spending, in a fiscally sustainable environment.<sup>31</sup> The DPL was also intended to enhance transparency and accountability by supporting policies to improve the administration of social assistance programs and promoting the use of systematic formulas to allocate resources in selected social programs and services.

3.2 **Relevance of Objectives is rated High**, although the articulation of the objectives is awkward, presenting challenges for their evaluation. Albania's National Strategy for Development and Integration 2014-2020<sup>32</sup> emphasizes the importance of moving from greater wealth to enhanced wellbeing, noting that wellbeing and equality of opportunity in Albania requires economic and social development that is cohesive, inclusive and balanced. It expresses Government commitment to increasing the equity and efficiency of the social assistance scheme (encompassing both NE and disability), stressing the importance of improved targeting of the poor, and enhanced efficiency and impact on the lives of the poor and disabled. Its health policies seek to ensure equitable access to health services, better service delivery and improved financial efficiency of the health system.

3.3 The objectives are also highly relevant to the Bank's current strategy in Albania. The CPS for Albania for the period FY11-FY14 emphasizes the importance of continuing efforts to reduce poverty and vulnerability. It highlights significant opportunities to improve targeting and administration of the NE for greater coverage of those most in need and for more efficient and transparent administration. It also highlights the ballooning disability fund expenditures, to the detriment of NE which shares the same budget envelope, and opportunities to improve eligibility criteria and their application for potential savings, enhanced transparency and efficiency of disability spending. On the health front, the CPS notes that reform of health service delivery and financing has not been fully implemented and serious problems remain to be confronted: (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 capacities. It

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<sup>30</sup> Statement of objectives is taken from the World Bank's Program Document of March 28, 2011. There is no statement of objectives in the Loan Agreement, as is typical for DPLs.

<sup>31</sup> This latter objective was synergistic with the HSMP investment operation, evaluated in Chapter 2.

<sup>32</sup> This document, in draft (June 2013) was cited to IEG as the most recent statement of national strategies and priorities. It was prepared just prior to the change in Government, but with the full participation of all political parties. Interviews have confirmed that this strategy is largely reflective of the new Government's vision, and any updates are expected to be minor, given its socialist orientation. The new Minister of Social Welfare and Youth expressed that he intends to do all he can to implement new social assistance policy passed under the DPL to eliminate the inefficiencies this legislation is intended to address. The new Minister of Health, as well, expressed his intention to address the pressing issues of health spending inequities and inefficiencies, as priority.



also cites ongoing efforts to transform health financing from input-based to performance-based.

3.4 The DPL objectives are also highly relevant to country conditions. Both the analytic work undertaken as part of the DPL preparation (and the ensuing dialogue) and IEG’s interviews with a wide range of actors and stakeholders<sup>33</sup> make it clear that (a) the challenges identified and addressed under this operation (Box 3.1.) continue to be of high priority, especially for the new socialist Government, and (b) that the DPL objectives were well poised to launch needed reform and make strategic headway in meeting those challenges.

3.5 **Design.** The DPL was designed to support legislative reform in two policy areas addressing the seven most pressing challenges identified through analytic work and sector dialogue (Box 3.1.). From the outset, this design was grounded in synergies expected to be achieved with two other investment operations: (a) the Social Assistance Modernization Project (SAMP), designed to support the implementation of social assistance policy reform achieved under the DPL (see Annex G for an overview of the SAMP); and (b) the HSMP, evaluated in Chapter 2 of this report, which included technical assistance for the design of the health financing law and support for reform implementation.

3.6 **Policy Area #1: Social Safety Net Effectiveness.** Four areas of support were envisaged. *First*, the DPL was to support measures to improve targeting of the NE Social Assistance Program at the central and municipal levels, revising the legislation to (i) include poverty as a criterion to determine allocations of grants for the NE program from central to municipal levels; and (ii) specify that a means-testing formula would be adopted to determine which households would be eligible to receive the benefits within each municipality. This revised formula was envisaged to incorporate (a) easily observed and verified (formal) incomes; and (b) other proxy variables (e.g., the imputed value of assets and possession of consumer durable goods) that represent observable characteristics with empirical correlation with poverty status and/or help predict “hard to measure” incomes. Special circumstances identified by local councils or social administrators could be considered, if incorporated into the single scoring formula, with transparent weights relative to other eligibility criteria.

3.7 *Second*, the DPL was to support changes to limit the rapidly increasing share of the disability component of social assistance spending. As a first step, the DPL would support a change in the indexation rules, moving from the current indexation (at least minimum wage increase) to an indexation linked to inflation. This would control spending, while maintaining the living standards of the disability beneficiaries.

3.8 *Third*, in order to make the social assistance system more proactive, the DPL was to support the introduction of a bonus for NE beneficiaries with school-age children as an incentive for daily school enrollment/attendance. Linking NE benefits to education-

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<sup>33</sup> Including the new Minister of Social Welfare and Youth, the new Minister of Health, a range of Government actors and implementers, development partners and others.

related incentives of NE families with school aged children was expected to improve the effectiveness of the program for long-run poverty reduction.

**Box 3.1. Priority Social Assistance and Health Sector Challenges Targeted under the DPL**

***Policy Area #1: Challenges impeding the effectiveness of social safety nets***

- Existing mechanisms for targeting the Ndihma Ekonomike Social Assistance Program benefits lack transparency and exclude a large share of the poor.
- Spending on social assistance has been shifting away from poverty reduction programs.
- The NE Social Assistance Program is currently “passive” – lacking proactive links to human capital or employment services that could potentially enhance its effectiveness for reducing poverty in the long-run.
- The administration of the NE Social Assistance Program needs to be strengthened.

***Policy Area #2: Challenges impeding the efficiency and equity of health spending:***

- Access to health care services by poor households is not universal and financial constraints limit utilization among the poor.
- Funding for Health Insurance is not based on systematic criteria
- The Health Insurance Institute needs to increase its efficiency as purchaser of health care services

*Source:* World Bank, March 2011.

3.9 *Fourth*, The DPL was intended to support the first steps to improving the administration of NE benefits. To this end, the automation of the NE benefits system was one of the main priorities of Government, but was understood to require time and significant funding, especially for creating electronic databases and intercommunication systems of various programs. Government had already completed an assessment of the operational aspects of the NE program, including information flows, financial flows, functional responsibilities and institutional capacity. The DPL was to support amendment of NE legislation to institutionalize the automation of the beneficiary registry, mandating the creation of a national registry of all applicants and beneficiaries.

3.10 ***Policy Area #2: Health Spending Efficiency and Equity.*** *First*, in support of increased transparency and access to basic care for all, the DPL was to leverage the passage of health insurance legislation, which would provide for the extension of health insurance coverage to all beneficiaries of the NE social assistance program and establish the principle of an explicit package of benefits for beneficiaries, providing the basis for assessing the cost of benefits. It was assumed that an explicit package of benefits would improve awareness of patients of what services they are entitled to receive; and the (eventual) pricing of these services was expected to reduce the scope for informal payments. The establishment of the principle under the legislation was expected to be followed by secondary legislation specifying the package and its costs.

3.11 *Second*, the DPL was to support a more systematic approach to health financing, including provisions under the legislation to maintain the payroll contribution for health insurance at 3.4 percent and to establish that transfers from the Treasury to HII on behalf of the uninsured would be based on the cost of providing a basic package of services. Above-cited secondary legislation was to determine the exact package and the provisions to cost it. *Third*, in 2009 the Government unified the resources for health under one single agency, the HII. This means, in principle, that the HII purchases most health

services, both at primary and hospital level.<sup>34</sup> The DPL was to support the development and co-signature (by HII and hospitals) of hospital performance contracts to support HII in its newly assigned role as sole purchaser of health services. In this early stage of hospital performance contracting, the HII was creating a performance analysis and contracting department.

3.12 An important feature of the DPL was its design as an integral element of a package of Bank support, composed of: (1) sound analytic work and dialogue, which provided the evidence base and commitment for reform; (2) the DPL, itself, providing technical support and political leverage for the design and passage of the legislation,<sup>35</sup> and (3) complementary investment operations: (a) for the social assistance policy area, medium-term support for the design and passage of secondary legislation and for reform implementation under a follow-on Social Assistance Modernization Project (SAMP) (approved by the Board of Directors on April 3, 2012, one year after approval of this DPL); and (b) for the health policy area, the HSMP (approved by the Board of Directors on June 14, 2006, and closed on June 30, 2012).

3.13 **Relevance of Design is rated Substantial, overall, but with some shortcomings on the health front.** For the most part, the project's design is consistent with its stated objectives and its causal chain clear. *In support of the first objective to support policy changes to improve the effectiveness of social safety nets*, under Policy Area #1, the DPL aimed to provide technical support to the design of legislation that would address the four priority issues (or “challenges”) that most undermined the effectiveness of social safety nets: ineffective targeting and lack of transparency in the NE social assistance program; the rapid growth in the disability component of the social assistance envelope, squeezing out the NE component; the lack of proactive links or synergies between the NE program and other human capital services; and the inefficient administration of the NE program. These technical *inputs* were directly linked to the *outputs* (which were the Government's prior actions under the DPL) – the passage of legislation setting the stage for improvements on each of these four fronts, with the leverage of the DPL. In turn, these *outputs* enabled the *outcome*: needed policy changes in place and being implemented to improve social safety net effectiveness.

3.14 *Likewise, in support of the second objective to support policy changes to enhance the efficiency and equity of health spending in a fiscally sustainable environment*, under Policy Area #2, the DPL, taking advantage of the technical support and dialogue under the ongoing HSMP, aimed to leverage the passage of legislation that would address priority issues that most threatened health spending efficiency (inadequate basis for efficient health insurance funding and inefficiency of the HII as sole purchaser of health care services) and equity (limited access and utilization of health services by the poor). The technical inputs provided under the HSMP, along with the leverage of the DPL, were

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<sup>34</sup> The Ministry of Health is still responsible for financing: public health activities, two mental health hospitals, the Licensing and Accreditation Center, blood banks and other minor activities.

<sup>35</sup> This was particularly the case for the social assistance policy area. The preparation of the health policy area, specifically, the preparation, vetting and refinement of the health insurance legislation (Law No. 10383 of February 24, 2011 “On Compulsory Health Care Insurance in the Republic of Albania”), was funded and technically supported under the ongoing HSMP.

designed to culminate in the achievement of Government's prior actions (or outputs) – the passage of health insurance legislation and the development and signature of performance-based contracts with hospitals. These outputs fed directly into the outcome: needed policy changes in place and being implemented to improve the efficiency and equity of health spending. Nevertheless the health design had shortcomings, relative to the social assistance design. *First*, the passage of the health insurance law was less strategic for DPL leverage than the social assistance legislation because it had already been designed and developed under the HSMP, as well as refined and vetted both within MoH and with Ministry of Finance, and strongly supported by them. In retrospect, the preparation/approval of the secondary legislation (defining and costing the health insurance benefits package, para. 3.10) may have been more appropriate for strategic leveraging under the DPL. Indeed, this secondary legislation still has not been prepared. *Second*, the HSMP closed in June 2012, two months after the DPL closed, and there has been no follow-on health investment operation since, a period approaching two years.<sup>36</sup> In short, there was no health investment operation in place to support implementation of these policy reforms. Both sets of legislation (under Policy Areas #1 and #2) were also directly supportive of the objective of improved accountability and transparency, as they contained provisions for improving the administration of social assistance and health programs and the use of systematic formulas to allocate resources more equitably and efficiently.

3.15 The choice of the DPL instrument was appropriate, especially for the social assistance policy area. The single-tranche disbursement to the Ministry of Finance was needed during the time of the economic crisis, thus providing leverage for the passage of this legislation. It properly embedded the dialogue, technical and strategic discussions, and adoption of social sector reform in the upper echelons of Government structures, all the while working with the two technical Ministries. The good timing and utility of this instrument were confirmed by the Deputy Minister of Finance and other high-level Government officials in the relevant sectors. The design recognized the comparative advantage of the DPL and linked it well with a follow-on social assistance investment operations poised to support the technical Ministry in the piloting and eventual nationwide implementation of the new social assistance laws and policies, including the design of secondary legislation and its implementation. The timing and links with the health sector operation were less fortuitous, as detailed in para. 3.13. The assessment of risks and risk mitigation provisions were sound, covering macroeconomic, technical, social and political aspects. Only the macroeconomic risk came to pass. This is detailed in the “Implementation” section of this Chapter.

3.16 **However, the M&E design of the DPL was weak.** Two sets of outcome indicators directly related to the DPL were articulated in the Policy Matrix (Annex 2 of the Program Document): (a) “short-term outcome indicators” (whose timeframe was not specifically defined); and (b) “outcome indicators” (expected to be achieved by the closing date of the DPL, April 30, 2012 -- a year after approval). A third set of (“medium-term outcome”) indicators was also included in the Policy Matrix, with the caveat that, although enabled by the DPL, these would be achieved under the investment

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<sup>36</sup> A Health System Improvement Project is currently under preparation and scheduled for Board approval around end-CY2014.

operations, beyond the timeframe of the DPL. The two sets of indicators established for the DPL were for the most part too ambitious for the short timeframe and (some) difficult to measure due to the infrequency of LSMS exercises.

**3.17 Implementation Arrangements.** The Ministry of Finance was responsible for overseeing the implementation of Government's prior actions included in the DPL, while the overall design and technical work was the responsibility of the two technical Ministries (Labor, Social Assistance and Equal Opportunities; and Health) and the Health Insurance Institute (HII). These technical agencies were also responsible ultimately for the implementation of new policy, under separate investment operations.

## **B. Implementation**

**3.18 Key Dates.** The project was identified in late 2009. Following preparation work throughout 2010, it was appraised in February 2011 and approved on April 28, 2011. Upon satisfactory evidence that the two conditions of effectiveness had been met (all prior actions taken; and the adequacy of the macroeconomic policy framework), the loan was declared effective on August 25, 2011, at which time the US\$25 million tranche was disbursed. Two supervision missions were conducted, respectively, in September 2011 and April 2012.

**3.19** Over and above the series of DPL missions (from 2009 to 2012), technical discussions and support took place, as well, in the context of the two complementary investment operations. The Social Assistance Modernization Project (SAMP), designed to support the implementation of the social assistance policy area of the DPL, was identified in mid-2011, appraised in January 2012, and approved on April 3, 2012, at the time of the closing date of the DPL. The series of missions to this end, helped sustain the momentum of the DPL and prepare for its sound and timely implementation. Aide-memoires on the supervision of the ongoing health operation (HSMP) indicate discussion of refinements to health financing legislation and possible inclusion in a DPL as early as 2006. But later health Aide-memoires<sup>37</sup> reveal concrete discussions and ongoing refinements of this legislation, with revised drafts and Bank extensive comments on the drafts, as well as references to relevant technical assistance, in annex.

**3.20 Macroeconomic Performance.**<sup>38</sup> At the time of the DPL preparation, Albania had been successful in sustaining the macroeconomic stability of the country amidst the pressures of the international financial crisis. In the aftermath of the global crisis in 2009, Albania had achieved a growth rate of 3.3 percent, one of the few positive growth rates recorded in Europe. Factored into this success were the positive performance of agriculture and services and the expansionary fiscal policy initiated before the crisis,

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<sup>37</sup> Five Aide-memoires between 2008 and 2010.

<sup>38</sup> For this analysis, baseline information on economic performance and Government commitment to maintaining macroeconomic stability are drawn from Government's Letter of Development Policy, March 18, 2011, annexed to the PAD of March 7, 2012. Information on actual economic performance is drawn from the Country Partnership Strategy Progress Report, April 18, 2013, cited by the Deputy Minister of Finance and the outgoing World Bank Country Director to the IEG mission as the most recent update of economic performance.

which offset the decline in the extracting industry and construction. Strong export recovery and good energy sector performance in 2010 caused growth projections to be optimistic. With the signs of global and domestic economic recovery, the fiscal deficit had been reduced to 3 percent of GDP in 2010 from 7.1 percent in 2009, precipitating a decline in the public debt from 59.7 percent in 2009 to 59.4 percent in 2010. Projections were optimistic based on the positive trends of key indicators, including the increase of credit to the economy, the increase of exports and private investment, a decline in the interest rate and the stabilization of the Lek exchange rate.

3.21 Against this backdrop, in its Letter of Development Policy for the DPL, the Government committed itself to sustaining the country's macroeconomic stability amidst the pressures of the international financial crisis. Specifically, the Government committed to:

- Achieving an annual GDP growth rate of 6.0 percent by 2012, up from a baseline of 3.5 percent in 2010;<sup>39</sup>
- Achieving a fiscal deficit ratio of 3.0 percent by 2012 and thereafter, from an estimated baseline of 3.1 percent in 2010 and a projected increase to 3.5 percent in 2011, before its anticipated return to 3.0 percent; and
- Reducing the public debt ratio from a baseline of 59.4 percent in 2010 to 56 percent by 2013. (This is in keeping with the legal limit set by Government in 2008 to maintain the public debt level below 60 percent of GDP.)

3.22 There were also uncertainties about the economy in 2010, especially with regard to the shaky financial and economic situation of Western Europe, the main destination for Albanian exports and the main source of remittances. In response to these, Government's Letter of Development Policy included provisions for making needed adjustments to ensure that fiscal consolidation commitments and targets would be preserved, in the event of lower than planned revenues. These provisions included: reserves (unallocated expenditures) in the 2011 budget of about 0.4 percent of GDP; buffers (budgets higher than expected needs) for several expenditure items equivalent to an additional 0.4 percent of GDP; and a mechanism to postpone part of capital spending until the mid-year budget review, at which time such expenditure could be initiated or further postponed, depending on revenue performance. Such provisions had already proven themselves, having been included and successfully utilized in the 2010 budget.

**3.23 *Achievement of economic and fiscal targets has fallen short of expectations. Albania's growth outlook has weakened substantially due mainly to the continued deterioration of the external environment.*** Actual growth rates were 3.5 percent in 2010, 3.0 percent in 2011 and 0.8 percent (estimated) in 2012; and they are projected to average 2.0 percent per annum during the period 2012-2015. This is in sharp contrast with the level of 3.6 percent achieved during the first three quarters of 2010 and the projections made in the DPL documentation of growth rates of 4.1 percent for 2010 (all

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<sup>39</sup> IEG questions the realism of a 6 percent growth target, in light of considerably more modest forecasts (of 3.2 percent for 2011 and 3.6 percent for 2012) made by the International Monetary Fund's Article IV Mission of 2010. (IMF 2010) The consequences of the financial crisis appear to have been apparent by mid-2011 when the loan was approved.

four quarters), 5.5 percent for 2011, and 6.0 percent for 2012. In short, the economic crisis led to lower remittances and exports, which in turn contributed to lower growth and fiscal revenues. An IEG evaluation of the Bank's response to the global crisis notes that Albania was a severe crisis country with a credit crunch the Bank aimed to help address. (IEG 2012)

**3.24** *While an expansionary fiscal policy helped to mitigate the negative effects of the global financial crisis in 2009, fiscal space became exhausted and public debt is projected to exceed 60 percent of GDP in 2012 and 2013.* In 2010, with fiscal space tight and revenue growth slowing, the Government cut expenditures by 9.5 percent at mid-year, reducing the fiscal deficit to 3.1 percent of GDP (down from 7 percent in 2009). Another mid-term fiscal adjustment (1.4 percent of GDP) was made in 2011 to keep public debt within 60 percent. However, Government did not make a mid-year fiscal adjustment in 2012, even though revenues were again lower than projected. This is because Government anticipated revenues from privatization. Ultimately, delays with completing privatization transactions, combined with a looming energy shortage, caused an increase in the fiscal deficit to 3.5 percent of GDP in 2012, pushing the debt level to 60.8 percent. Moreover, there are sizable outstanding bills and accumulated arrears for public works and full VAT reimbursements (about 200 million euros, according to IMF estimates). In December 2012, Parliament approved the removal of the 60 percent ceiling from the organic budget law, without proposing any other limit or goal. Albania's 2013 budget targets a general government fiscal deficit of 3.4 percent and predicts a further increase in public debt. Both the public debt level (60.8 percent in 2012) and the fiscal deficit (3.5 percent in 2012) failed to achieve targets set under the DPL/Government's Letter of Development policy, respectively, a public debt level of 56 percent by 2013, and a fiscal deficit of 3.0 percent by 2012 and thereafter. Indeed, Parliament's removal of the 60 percent legal limit for the debt level and a revised fiscal deficit target of 3.4 percent under the 2013 budget give cause for concern.

**3.25** The CPS 2011-2014 highlights the importance of critical steps for improved economic management, especially: clearing arrears to private companies, together with establishing an effective mechanism for commitment control; lowering public debt over the medium-term. External imbalances improved in 2012, but remain high. The financial sector has remained largely stable vis-à-vis the ongoing Eurozone crisis, but faces escalating risks derived from the prolonged unfavorable external environment and the continued deterioration of banks' loan quality. The Bank of Albania has been proactive in adopting prudent measures to safeguard financial stability but continued efforts are needed.

**3.26** The recent sluggish economic performance has likely been insufficient to reduce poverty. Although Albania experienced rapid poverty reduction up to 2008, the effects of slower growth appear to be placing a large part of the population under increasing strain. Preliminary results from the 2012 LSMS indicate a slight increase in poverty, a reversal of the positive trend of poverty reduction since the new millennium.

**3.27** **M&E Implementation is modest.** Because the outcome indicators set for the DPL were more dependent upon the follow-on implementation assistance envisaged under the SAMP and because of the inadequate frequency of LSMS exercises (and the

continued unavailability of the LSMS 2012 results), there was very limited M&E work undertaken during the short implementation period of the DPL.

### **C. Achievement of the Objectives<sup>40</sup>**

#### **PDO#1: To support policy changes to improve the effectiveness of social safety nets: *Substantially Achieved***

3.28 *Prior Actions established a sound legislative framework for improving the effectiveness of social safety nets.* Through its prior actions under the DPL, Government has passed legislation to: (i) strengthen the mechanisms of the NE program to allocate funds and target the poorest of the poor; (ii) change the indexation formula of the disability benefits package program to control the share of resources allocated to this program, which is growing disproportionately; (iii) introduce incentives for investing in human capital by providing an additional benefit under the NE program linked to school enrollment and attendance for families with school-age children; and (iv) mandate the creation of an automated national registry for applicants and beneficiaries of the social assistance program. This legislation creates an enabling environment for the implementation of these reforms, which address the most pressing challenges to social safety nets effectiveness.

3.29 *Implementation of social assistance reform is well underway with strong Government commitment, after some initial delays caused by a change in Government.* Once the new Government was in place (fall 2013), the Bank acted expeditiously with policy briefs and policy dialogue with the new Government, which fully embraced this new legislation and expressed its commitment to move forward with its implementation.

3.30 Indeed progress in implementation is now well underway. Training of social assistance administrative staff at all levels of the system (central level and in the three pilot regions, covering 50 percent of the entire population) had already taken place. IEG interviews with many of these staff indicated their full knowledge of the law, their strong commitment to its implementation and their solid experience and capacity. The secondary legislation on the implementation of the proxy means test for improved poverty targeting (referred to as the Unified Scoring Formula in Albania) in three pilot areas was approved in December 2012. The management information system for the poverty targeted program is established and fully operational and applications are now being accepted using this system (and the proxy means test) as part of a test phase. Social Assistance program managers and staff interviewed by IEG were emphatic in their assertion that this registry (already developed and being piloted) will facilitate their work. It is also revealing its utility in reducing the exorbitant time commitments and costs of the poor to access social assistance (associated with acquisition/purchase of documentation to demonstrate their eligibility for NE support). Full implementation of the new targeting methodology and the MIS started in May in the three pilot areas.

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<sup>40</sup> For more detail, Annex H presents a matrix on each of the two project objectives assessing outcomes against objectives and performance indicators.



3.31 Over and above the indexation of disability benefits to inflation, reform of disability is also intended to address the increase in the number of beneficiaries through the redesign of eligibility criteria, reduction of fraud, and the building of a MIS for disability. Interventions for implementing disability reform, which is more politically complex, are planned to be undertaken by Government once the NE pilot is well underway.

3.32 Additionally, in principle the Bank and the former Government had agreed that NE bonuses linked to school attendance (provided for under the new law) would be tackled after first generation reforms on targeting methodology and modernization of systems are implemented. However, the current Government was keen to prepare the legal ground for this eventual reform. It has already drafted the secondary legislation on both education (linked to secondary school attendance) and health (linked to full vaccination of children) bonuses; and it is now preparing for approval of this secondary legislation with plans for its implementation after pilot implementation of new targeting methodology and MIS.

3.33 *While ambitious outcome indicators established under the DPL have not yet been achieved, Government commitment and its notable progress in social assistance reform implementation provide strong indication that improved effectiveness of social safety nets is being achieved and related targets are likely to be achieved, albeit later than initially expected.* Changing the targeting methodology is expected to address the currently high exclusion errors and also improve the governance of the transfers as under the new targeting system the discretionary aspect of eligibility decisions are taken away. Eligibility is based solely on objective, transparent criteria. With implementation now underway: (a) an authorizing environment has been established for a more transparent and predictable block grant allocation on the basis of poverty indicators; (b) increased percentage of poor receiving means-based social assistance (from 22 percent in 2008 to 30 percent in 2012) is delayed, but very likely to be achieved; (c) increased share of benefits accruing to the poor (from 42 percent in 2008 to 60 percent in 2013) is also delayed, but likely. But this is estimated to take another year or two.

3.34 Disability reform implementation under the project is expected to culminate in the achievement of outcome targets: (a) five percent savings under disability spending due to indexation reform (a target initially set for 2012) is likely to be achieved (quite possibly exceeded), but later than planned; and (b) stabilization in the number of disability beneficiaries as a (unspecified) percent of the population is also likely and an explicit focus of the SAMP. Once bonuses for school attendance and vaccinations are activated (relevant secondary legislation has already been prepared by Government), they are expected to increase school attendance and vaccination rates of children from NE beneficiary families.

**PDO#2: To support policy changes to enhance the efficiency and equity of health spending: *Modestly Achieved***

3.35 **Improved health spending efficiency has not yet been achieved, and implementation support to this end has ceased with the closing of HSMP two years ago.** Additional support will be needed.

3.36 ***Prior actions established a sound legislative framework for improving the efficiency of health spending.*** Through its prior actions the Government has (i) passed legislation to introduce more predictable fiscal rules to finance health (maintaining health insurance payroll contributions at the current 3.4 percent level,<sup>41,42</sup> and mandating that health transfers be based on the costs of services, among other criteria);<sup>43</sup> (ii) transferred the responsibility of financing hospitals to HII (already responsible for PHC financing) in order to unify the publicly funded purchasing of health services under one agency; and (iii) prompted the signature of performance contracts between HII and the 42 hospitals in Albania.

3.37 ***However, implementation of this new framework supported under the Health Sector Modernization Project (HSMP) has been mixed, and outcomes have not been achieved.*** The health financing law protects employers and employees from any increases in their 3.4 percent payroll contribution to health insurance, of which 1.7 percent is paid by the employer and 1.7 percent paid by the employee. But the cost of services is not yet used as a basis for the public transfers for health financing, because the definition and costing of the package of services offered at the PHC and hospital levels are still ongoing. USAID and MoH published a document in December 2008, which defines the characteristics of a typical health center as well as the basic package of services in the health center. But these have not been costed. USAID has also published a document, undertaken in conjunction with MoH and HII, which proposes definitions of hospital services packages for district, regional and tertiary hospitals, along the lines of the hospital rationalization plan. But the cost implications of these have not been fully assessed.

3.38 HII is officially assigned responsibility for the purchase of all health services (PHC and hospitals) since 2009, but its ability to fulfill this role has been constrained. Even though performance contracts were signed with 42 hospitals, (i) the hospital budgets are still prepared and approved by the Council of Ministers on the basis of historical budgets (number of beds) and not on the basis of services provided and performance; and (ii) 95 percent of hospital financing is still channeled through the Treasury, and paid on the basis of expenditure receipts, not performance. HII is responsible for distributing only 5 percent of the hospital budgets. The only exception to this current practice is the Durres Regional Hospital, whose budget is channeled through HII, due to its special status as a pilot hospital.

3.39 The Health Financing Law mandate (that the transfer of resources for the purchase of health services be based on the definition and costing of the package of services to be offered at each level of the referral system) has the potential to enhance transparency especially for hospitals, whose current budgets (based on the number of

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<sup>41</sup> Article 8 of Law No. 10383 of February 4, 2011 on “Compulsory Health Care Insurance in the Republic of Albania.”

<sup>42</sup> This measure precedes by several years the election of the new Government in 2013, which is now contemplating a tax-based system for financing universal health care.

<sup>43</sup> Articles 10 and 30 of Law No. 10383 of February 4, 2011 on “Compulsory Health Care Insurance in the Republic of Albania.”

beds) culminate in highly inefficient allocation of scarce resources. But it has yet to be implemented.

**3.40 Improved equity of health spending has not yet been achieved, and implementation support to this end has ceased with the closing of HSMP.** Additional support will be needed.

**3.41 *An additional prior action established a sound legislative framework for improving the equity of health spending.*** Article 5 of Law No. 10383 of February 4, 2011 on “Compulsory Health Care Insurance in the Republic of Albania” extends health insurance coverage to 100 percent of social assistance beneficiaries.<sup>44</sup>

**3.42 *However, this measure has not been implemented under HSMP – or the target achieved.*** The Government has not implemented extension of free health insurance coverage to 100 percent of NE recipients, as articulated under the law. Fiscal concerns have prevented the extension of this coverage for the moment; and the fiscal impact of this policy (based on the definition and costing of the package of services) has not yet been fully assessed. Currently, public health insurance is estimated to cover about 60 percent of the population, but only half of the poor (World Bank 2014).<sup>45</sup> The new Government has a vision of universal health coverage to be financed by the State. Implementation of this policy still requires the definition of the package of services to be offered and the costing of this policy. While this policy would in principle provide free health services for all the population, including NE beneficiaries, the likelihood of this outcome is difficult to predict at this point in time.

**3.43 *The outcome associated with reductions in health spending by the poor is difficult to document, and, in any case, could not be attributed to this legislation, as it has not been implemented.*** Data is limited to assess any trend of reductions in spending on health by the poor,<sup>46</sup> but available evidence suggests that the poor’s financial access to services remains very limited and unchanged (paras. 2.25-2.29). In any case, data and trends should be interpreted with caution, since low spending by the poor for health care may be reflective of their avoidance of health care services, as revealed in the 2013 USAID study, rather than of their improved affordability. World Bank secondary analysis of LSMS data estimates that in 2012 the poverty headcount increased from 14.3 percent to 20.3 percent when OOP spending on health is subtracted from household consumption. This means that the poverty rate increased by as much as 42 percent, as a

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<sup>44</sup> While not specified among the DPL prior actions, it is significant to note that Article 5 of this Law specifies additional categories of economically non-active people who would be covered under the health insurance: beneficiaries of Social Insurance Institute; disability beneficiaries; people registered as unemployed jobseekers through the National Employment Service; foreign asylum seekers in the country; children under the age of 18 years; pupils and students under the age of 25 years, provided they do not have incomes from business activities; and categories of persons defined by special laws.

<sup>45</sup> While coverage is inequitable, with 52 percent coverage of the lowest quintile of per capita consumption and 67 percent coverage of the highest quintile, this represents an improvement over 2008, when 27 percent of the lowest quintile was covered versus 54 percent of the highest quintile.

<sup>46</sup> A soon-to-be-issued PER may shed more light on this.

consequence of health-related spending, higher than the increase of about one third, calculated for 2008 (from 12.5 percent to 16.9 percent) (World Bank 2014).

**3.44 Counterfactual and Attribution.** Systematic interviews with a wide range of informants and IEG's own assessment on the ground explored the counterfactual of no DPL. Evidence is overwhelming that without the DPL, the social assistance legislation may not have been passed at all. At the very least, it would have experienced long delays and its quality – both technical and strategic – would have suffered. Respondents were unanimous in noting that, had there been no DPL, there would be no SAMP. This would mean continued lack of transparency, abuse of funds, inefficient targeting and resource allocation and ineffective administration. No other development agency was providing support to this end. The Ministry of Social Welfare would not have been able to achieve the passage of these reforms on its own, from technical, political and strategic perspectives. Thus, an attempt to achieve this legislative reform under an investment operation is not likely to have been successful. This assessment reflects the views of the Ministry of Finance as well as leadership and staff of the Ministry of Social Welfare and Youth (among others), encompassing: those from the previous Government, when the DPL was designed and implemented, those who have been recently appointed/recruited under the new Government, and those who worked under both Governments.

**3.45** On the health side, respondents were mixed in assessing the counterfactual of the DPL, even within the Bank's team. This is in large part because the HSMP, with its considerable and highly appreciated technical assistance on health financing and hospital reform, was ongoing, in parallel with the DPL preparation and implementation. Many expressed the view that the health financing legislation would have been passed even without the DPL, given the quality of the technical work, involvement of key stakeholders in its vetting and strong Government commitment (Ministries of Health and Finance, both) to its passage, all supported and nurtured under HSMP. The DPL probably did provide political and financial leverage that may have further strengthened high-level, Government-wide commitment to the passage of the legislation. Technical exchanges and reviews of the legislation under the HSMP, documented in the series of HSMP and DPL Aide-memoires, finally did culminate in its passage. A comparison of the March 2010 draft of the health insurance law and the final version of the law as approved by Parliament (February 2011) reveals that they are virtually identical substantively, an indication that the technical work had been supported and refined by the HSMP before the DPL picked it up as a policy area.

## **D. Other Ratings**

**3.46 The project's Outcome rating is Moderately Satisfactory.**<sup>47</sup> The project's objectives are highly relevant to Albania's National Strategy for Development and

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<sup>47</sup> There is a marked difference between this PPAR's rating of the project's outcome and IEG's unsatisfactory rating of the project's outcome based on its 2013 desk review of the Region's Implementation Completion and Results Report. This PPAR upgraded IEG's initial ratings of: (i) design from modest to substantial because the underlying logic and the good choice of instrument became more evident during the course of the field work, especially for social assistance, and the choice of outcome indicators and targets, while overly ambitious, was more of an M&E design issue, not reason enough for a modest rating; and (ii) efficacy of the first (social assistance) objective from modest to substantial because

Integration 2014-2020, which expresses Government's commitment to increasing the equity and efficiency of the social assistance scheme and to ensuring equitable access to health services and improved financial efficiency. These commitments are also emphasized in the Bank's CPS for Albania (FY11-FY14). The objectives are also highly relevant to current country conditions, as expressed by a range of actors and stakeholders interviewed by IEG, and directly observed by IEG. Project design is substantially relevant with a clear causal chain containing technical and strategic support to the objectives, and an appropriate choice of the DPL instrument, complementing (i) the technical support of the Bank's analytic work, technical assistance, and policy dialogue; and (ii) the health and social assistance investment operations designed to support reform implementation.

3.47 The objective to support policy changes to improve the effectiveness of social safety nets was substantially achieved with the passage and ongoing implementation of well-designed, relevant legislation. Full achievement of the outcome indicators is likely, but delayed, since the start-up of the social assistance investment operation was delayed with the transition in Government. The objective to support policy changes to enhance the efficiency and equity of health spending was modestly achieved. While all prior actions were undertaken, the outcomes expected from these prior actions, supported in parallel by the now closed HSMP operation, were not achieved. Health insurance coverage has not been extended to social assistance beneficiaries, the cost of a defined package of services is not used as a criterion for financial transfers; hospital budgets are compiled on the basis of historical budgets and not on the basis of services delivered or performance; and the majority of hospital financing is channeled through the Treasury, not HII. The objective of enhancing transparency and accountability of selected social programs and services was substantially achieved with the passage of social assistance and health financing legislation mandating the use of systematic formulas to allocate resources and improvements to program administration.

3.48 **Risk to Development Outcome is Moderate overall. *Financial risk is significant.*** The financial impact of the social assistance reforms has not yet been fully assessed. It is expected that reforms to NE eligibility criteria, resource allocation, and their more rigorous application will result in better targeting of the benefits to those most deserving (the poor). It is also anticipated that this rigor will eliminate the ineligible (richer) families from the program. The net effect of this program is likely to result in more efficiency, but it may end up being more costly, if more people enter than are eliminated. The new legislation also expands benefits to different categories of orphans and to victims of domestic violence. Respondents were emphatic that support to these previously neglected categories of eligible people is well justified and long overdue. But the addition of these people will incur additional costs to the program. The indexation of disability benefits to inflation is expected to contribute to controlling the rapid growth in these benefits (slower than the previous indexation to minimum wage increases). But the

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of continued, notable progress in social assistance reform implementation and the increased likelihood of achieving related outcome targets, albeit with delays. Both the 2013 desk review and this PPAR rate efficacy of the second (health) objective modest, but the 2013 exercise rates two sub-objectives, whereas the PPAR provides one rating for the health objective.

more substantial savings should occur through a second phase of disability reform, aimed at the review and more rigorous application of disability eligibility criteria and the elimination of current beneficiaries who do not meet these criteria. Clearly, this is a more challenging, politically complex endeavor. The decision not to implement the school bonus immediately under the SAMP was linked to concerns about its affordability, as well as to concerns about Government's implementation capacity. If it is undertaken in a second-phase reform, the fiscal implications of this decision will need to be revisited. Even though it was provided for under the health financing legislation, the extension of health insurance benefits has not yet been extended to NE beneficiaries because of fiscal concerns.

3.49 ***Institutional risk is moderate.*** The SAMP is well designed and well placed to strengthen institutional capacity to implement social assistance reforms. The leadership of the MoSW&Y and the management and staffing of the social assistance program, at the central and regional levels, appears for the most part to be well-qualified and committed. This includes the continuity of experienced, key managers and staff who are capable and have a good knowledge and institutional memory of program efforts and technical work, as well as newly recruited managers and staff with strong qualifications. There are still problems of staff quality, in some cases, brought to IEG's attention in the field. Under the SAMP, implementation support will include: secondary legislation, systems building, training, monitoring and evaluation and learning. All of these should ensure institutional capacity for social assistance. The decision to postpone the implementation of the school bonus reform due to capacity constraints was a sound one.

3.50 There are more concerns about the institutional risk on the health front. The HII is establishing a department and capacity to finance hospitals based on services delivered and performance, which will take considerable time and effort and require technical support. Efficiently-run, performance-based hospitals will depend on the implementation of hospital reforms (autonomy, rationalization), which has thus far been lagging. Better coordination and collaboration between MoH and HII will be critical to this end. A follow-on Bank operation and other development partner support are expected to address these challenges.

3.51 ***Political risk is moderate.*** The new socialist Government is very supportive of all of the reforms supported under the DPL, which mesh well with its electoral platform and medium-term strategy. A number of informants expected there would be some pushback from local government officials, whose decision-making authority on the award of social assistance has been reassigned to the local social assistance offices. The Government's new vision of universal health coverage financed by the state budget (taxes) vs. health insurance does not undermine the (still unattained) objective of extending health insurance (free health coverage) to the poor. But it may well change how it is approached. The main reason policy-makers are hesitant to embrace this fully is linked to issues of affordability.

3.52 **Bank Performance is Moderately Satisfactory overall. *Quality at entry is Moderately Satisfactory.*** The quality of the DPL preparation and design is grounded in the high quality of the analytic work and sector dialogue of the Bank. A trust-funded technical assistance program supported robust technical work to ensure the technical

quality of the social assistance policies and reforms. And rigorous, respectful dialogue (through a series of consultations, workshops, and technical discussions) enhanced the understanding of Government of the key issues undermining their social assistance efficacy and efficiency and engaged them in the reform process. Respondents consistently expressed their appreciation of the inclusion in this technical work of both the relevant experience in other countries in Europe and the rest of the world and the advice that was specific and responsive to Albania's particular context. The Bank's work on the structural, financial and macro-economic aspects was also sound. Its assessment of the macroeconomic situation and fiscal stability was grounded in the knowledge available at the time of an unfolding fiscal crisis, although some note that targets and projections were optimistic in light of IMF projections made in 2010 (para. 3.20). Its advice to Government on maintaining fiscal stabilization during the crisis was sound.

3.53 The Bank's inputs and processes were intensive and supportive, provided over a series of five to six DPL-specific missions during a two-year period between 2009 and 2011, over and above a series of HSMP missions reviewing and discussing revisions to the health legislation and HSMP technical assistance. The risk assessment was sound, raising relevant macroeconomic, political, technical and social risks, all with reasonable mitigation measures. The only risk that came to pass was the macroeconomic one (paras. 3.19-3.25). The health sector's delay in implementing financing reforms and the affordability of reforms were not raised as risks, nor was the absence of a follow-on health investment raised as a risk to successful reform implementation. Both the quality and the continuity of the team and dialogue were consistently raised as strong features of the Bank's performance.<sup>48</sup> An important shortcoming of the Bank's quality at entry was the choice of DPL outcome indicators, which were too ambitious and inappropriate for measuring achievement of the DPL objectives and more closely related to the SAMP.

3.54 ***Quality of Supervision is Moderately Satisfactory.*** The Bank was well focused on the relevance and development impact of the reforms. It carried out two supervision missions during the one-year implementation period of the operation, providing sufficient resources for tracking performance. Its role in ensuring adequate transition arrangements was pivotal tightly linking the passage of reforms under the DPL to implementation of those reforms, respectfully, under the HSMP and the SAMP. One shortcoming was a moderate lack of candor and quality in reporting on the achievements of the project. This was likely linked to the above-cited problem of the inappropriate, overly ambitious outcome indicators established for this DPL.

3.55 ***Borrower Performance is Moderately Satisfactory overall. Government performance was Moderately Satisfactory.*** The Ministry of Finance and the Prime Minister were committed to the project and oversaw the design of the reforms and their passage in Parliament. And they were strongly supportive of the transition arrangements assured through the SAMP and HSMP. The Government has appointed capable people

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<sup>48</sup> The first TTL became the Sector Manager in that Unit and was succeeded by a qualified member of the team who had been involved in the technical work and dialogue. The Tirana-based team member, who was also the health TTL, provided continuity from the outset and later assumed responsibility as TTL. Yet another team member on the DPL became the TTL for the SAMP, ensuring seamless support in the implementation of social assistance reforms.

to lead and implement social assistance reform. Frequent changes in the health Minister position and related changes to MoH staffing that were more responsive to politics than to needed skills and capacity undermined the ability of the Ministry to implement reforms expeditiously. Two moderate shortcomings were: (a) failure to take recommended measures to maintain fiscal stability under the DPL; and (b) failure to release the LSMS 2012 data in a timely fashion, which would have facilitated the tracking of some of the outcome indicators.

**3.56 Performance of the Implementing Agencies is Moderately Satisfactory.** The Ministry of Social Welfare and Youth was involved, informed and motivated to prepare the legislation and, under the follow-on SAMP, poised for its successful implementation. The MoH collaborated with the HSMP-financed technical assistance in the preparation of the health finance legislation. But follow-through in its implementation has been lacking.

**3.57 Monitoring and Evaluation was Modest.** Two sets of outcome indicators established for the DPL were, for the most part, too ambitious for the short timeframe and (some) difficult to measure due to the infrequency of LSMS exercises (para 3.15). Because the outcome indicators set for the DPL were more dependent upon the follow-on implementation assistance under the SAMP, and because of the inadequate frequency of LSMS exercises (and continued unavailability of the LSMS 2012 results), there was very limited M&E work undertaken during the short implementation period of the DPL (para 3.26).

## 4. Lessons

4.1 This combined evaluation of the Health Systems Modernization Project and the Social Sector Development Policy Loan has revealed a number of cross-cutting lessons. Both projects: were grounded in analytic work and technical assistance; supported far-reaching reforms; sought to exploit synergies across various forms of Bank support and lending instruments; and faced a range of challenges inherent in reform implementation.

4.2 A number of common lessons emanating from these two projects are presented below. These lessons become even more interesting when juxtaposed against the lessons distilled from two relevant IEG thematic reviews of, respectively: (a) the effectiveness of the World Bank's analytic work and technical assistance (Box 4.1.); and (b) the effectiveness of the World Bank's support to health, nutrition and population sectors, with a focus on health reform (Box 4.2.). Each of these reviews was world-wide in scope and provides insight and perspective to experience gleaned from the two Albania projects that are the subject of this review.



**Box 4.1. Cross-Regional Factors Contributing to the Effectiveness of the World Bank’s Analytic Work and Technical Assistance**

- When Government capacity was lower, analytic work and technical assistance were less effective.
- Government receptivity also influenced effectiveness of analytic work.
- Analytic work and technical assistance products of lower technical quality were less effective.
- Analytic work of higher quality costs more.
- Close collaboration with clients, from the initiation of the task through the formulation of recommendations, was important for analytic work and technical assistance to be influential.
- Where partnership with clients made a difference, a variety of approaches was equally effective, depending on country conditions. Where Government capacity was limited, partnering in the production of narrowly focused tasks was more effective than partnering on more broadly scoped tasks.
- Whether the client specifically requested the analytic work and technical assistance did not matter for effectiveness, although client buy-in was still important.
- Sustained follow-up beyond one-off discussion was important for analytic work and technical assistance effectiveness.
- The scope of discussion for effective analytic work and technical assistance varied, depending on the country context and the topic of the analysis.
- Translation is important to client countries.

*Source:* “Using Knowledge to Improve Development Effectiveness: An Evaluation of World Bank Economic and Sector Work and Technical Assistance 2000-2006,” World Bank, Independent Evaluation Group, 2008.

4.3 ***The high quality of the Bank’s analytic work and technical assistance is necessary but not sufficient for their effectiveness. Also important are the involvement and buy-in of the Government and other key stakeholders and the strategic packaging of this support with other Bank products and services.*** Both the Health Sector Policy Note (2006) and the Social Assistance Policy Note (2010) were carried out with the involvement of key Government policymakers and implementers, in consultation with other partners, from the design to dissemination. Their purpose was to generate an evidence base, which would: enhance understanding of Government and other stakeholders of sector performance and issues; inform options for policymaking, reform and prioritization of interventions; and generate widespread commitment to policy reform and implementation. They involved rigorous, respectful dialogue, through a series of consultations, workshops and technical discussions. These two pieces of analytic work were highly successful in informing and influencing reform. They were spontaneously cited by a wide range of informants (within and beyond Government) as having contributed greatly to the evidence base and to the agenda for reform; and they continue to be the point of reference for documenting and shaping the reform agenda.

#### Box 4.2. Cross-Regional Lessons on Health Reform

- Reform based on careful prior analytic work holds a greater chance of success, but analytic work does not ensure success.
- The failure to assess fully the political economy of reform and to prepare a proactive plan to address it can considerably diminish prospects for success. Political risks, the interest of key stakeholders, and the risk of complexity – issues the evaluation studies found to be critical – are often neglected in risk analysis in design documents for health reform projects.
- The sequencing of reforms can improve political feasibility, reduce complexity, ensure that adequate capacity is in place, and facilitate learning. When implementation is flagging, the Bank can help preserve reform momentum with complementary programmatic lending through the Ministry of Finance, as it did in Peru and the Kyrgyz Republic.
- M&E are critical in health reform projects – to demonstrate the impact of pilot reforms, to garner political support, but also because many reforms cannot work without a well-functioning MIS.

*Source:* “Improving Effectiveness and Outcomes for the Poor in Health, Nutrition and Population: An Evaluation of World Bank Group Support since 1997,” World Bank, Independent Evaluation Group, 2009.

4.4 The large package of technical assistance provided under the health project was of high quality (as noted by a broad range of respondents, and verified by IEG’s own review of the technical assistance reports). The Bank’s team was relentless in its effort to ensure the uptake of this assistance. Aide-memoires are full of reminders insisting that Government assign counterparts to work with technical assistants and that the Technical Working Groups become fully staffed and functional in order to contribute to, as well as vet, this work.

4.5 ***One-tranche DPLs can be transformative and support reform momentum if (i) they build on solid analytic work; (ii) they can effectively leverage critical policy change (e.g. legislation) that may not gain sufficient traction through sector dialogue alone; and (iii) they are supported by continuity in the sector policy dialogue and lending after the DPL closes.*** The health sector and social assistance supports provided by the Bank were each made up of three complementary areas of support. *First*, as noted above, the undertaking of sound analytic work generated an enhanced evidence base for the country, provided relevant perspective on other countries’ experiences, engaged Government in meaningful dialogue, enhanced their understanding of social sector challenges, and helped inform the establishment of policies priorities. *Second*, the one-tranche DPL provided the leverage for the passage of essential legislation, based on the analytic work that was critical in the design and launch of policy reform. *Third*, health and social assistance investment operations provided financial and technical support for reform implementation. All three were complementary and at the same time supportive of common objectives. A shortcoming on the health front was the absence of an investment operation after the DPL’s closing to provide reform implementation support.

4.6 When the new Socialist Government took power in 2013, the Bank’s health and social assistance teams prepared policy briefs drawing on the analytic work and technical assistance provided under the projects to brief the new leaders and implementers on the evidence and reform agenda. The health team was especially devoted to making available to the new Government the full range of technical assistants’ reports, whose uptake by the previous Government was somewhat modest. Both new Ministers reported to IEG that the Bank’s proactivity and availability in this regard helped them to become

well briefed on critical aspects of their newly acquired portfolios; and both commented on the quality and rigor of the analytic work and technical assistance and its relevance to the achievement of their goals. This technical assistance is thus well poised to inform and support the new Government in its reform process.

**4.7 *Political economy is critical to factor into reform design and risk management. Neglect of some aspects of political economy is likely to have undermined prospects for the full and successful implementation of health reforms under the HSMP.*** Looking back, there were certain groups that might have been more effectively considered and involved for certain reforms. Efforts to improve the access, quality and affordability of primary health care services and a more efficient use of hospital services would have been better undertaken with the full involvement of civil society, including journalists, and consumers, whose perspectives and behaviors are critical to the success of these reforms. The results of the study of consumers' perspectives on health services, cited in this report (Box 2.2.), provide great insight on impediments to service quality and affordability that were not sufficiently incorporated into the reform. Uncertainties and tensions about the relative roles, responsibilities and mutual accountabilities of MoH and HII are also likely to have undermined the reform process. Vetting the implications of the reform process within and between these institutions may have eased tensions and clarified their partnership and complementarities, at all levels of the system, and set an agenda for resolving issues of overlap in mandate.

**4.8** Greater involvement of two categories of health professionals may also have been warranted. Several respondents pointed out that the faculty of medicine, practicing at Tirana Tertiary Hospital, also had important influence on the success of reforms, especially with regard to service quality and hospital and service provider accountability. Key respondents noted that the faculty of medicine was neither adequately involved nor was it held accountable for reform implementation; and some have noted that the faculty's indifference to key reforms was a factor in their failure. Given their strong presence and key potential role in quality assurance, the fuller involvement of nurses – both in sector dialogue and in reform design and implementation – is also likely to have enhanced prospects for reform success.

**4.9 *The sequencing of reforms under the Social Assistance DPL and its follow-on implementation support is likely to have mitigated potential implementation setbacks associated with political feasibility, capacity and fiscal constraints.*** The reforms to the NE social welfare program were put in a first phase, as there was strong political support for improving the effectiveness of this program, targeted to the poor. Efforts to contain the growth in disability benefits were deemed to be more politically contentious and thus were programmed in a second phase of support under SAMP. For reasons of limited capacity and fiscal constraints, both the Bank and the Government agreed to postpone into a later phase the linking of welfare benefits to bonuses for school attendance and child immunizations.

**4.10 *The design and implementation of pilots to test and fine-tune reforms and the establishment of well-functioning MIS and M&E systems are critical to health and social assistance reform, as they can accommodate learning, provide evidence of the feasibility and benefits of such reform and garner political support.*** HSMP failed to

design, launch, implement and evaluate the pilots envisaged to test: (i) hospital autonomy models;<sup>49</sup> and (ii) the hospital rationalization plan recommendation to consolidate one regional hospital and one or more district hospitals under one administrative unit.<sup>50</sup> Such pilots would have demonstrated the feasibility and benefits of these approaches and informed their refinement and possible scale-up through an evidence-based learning process. Well-documented evidence is likely to have been instrumental in alleviating political pressures to maintain the status quo. Indeed, the failure to fully evaluate and actively showcase the successes of the Durres Hospital pilot (under implementation, with USAID and other assistance, for a decade) was a missed opportunity to make a compelling case – both technically and politically – to scale up this model of hospital autonomy. The failure to implement these pilots undermined the achievement of the objective to improve hospital governance and management. Likewise, the failure to establish a well-functioning MIS for tracking overall sector performance also likely undermined the implementation and tracking of sector reform.

4.11 Thanks to the follow-on support of the SAMP, the implementation of the social assistance law is well on track, with a well-designed pilot in the three most populous regions currently underway, along with the establishment and launch of a MIS – a registry of all social assistance beneficiaries and a viable M&E system. This bodes well for successful reform.

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<sup>49</sup> The piloting of reforms of hospital management and governance structures was included in the original project design (Box 2.1, Component C (iii)), but it was not implemented (para. 2.55).

<sup>50</sup> The testing of the hospital rationalization strategy on a pilot basis in two selected districts was added to Component C. as a part of the second (September 2011) restructuring (Annex E, Table E-1), but it was not implemented (para. 2.54).

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## Annex A. Basic Data Sheet for Social Sector Reform DPL Project (P116937)

### SOCIAL SECTOR REFORM DPL (P116937) PROJECT

#### Key Project Data (amounts in US\$ million)

	Appraisal estimate	Actual or current estimate	Actual as % of appraisal estimate
Loan amount	24.48	25.01	102.16

#### Cumulative Estimated and Actual Disbursements

	<i>FY12</i>
Appraisal estimate (US\$M)	24.48
Actual (US\$M)	25.01
Actual as % of appraisal	102.16
Date of final disbursement: 09/15/2011	

#### Project Dates

	Original	Actual
Initiating memorandum	08/13/2009	07/07/2010
Negotiations	03/15/2011	03/21/2011
Board approval	01/07/2010	04/28/2011
Signing	06/17/2011	06/21/2011
Effectiveness	08/24/2011	08/25/2011
Closing date	04/30/2012	04/30/2012

#### Staff Time and Cost

Stage of Project Cycle	Staff Time and Cost (Bank Budget Only)	
	No. of staff weeks	US\$ Thousands (including travel and consultants costs)
<b>Lending</b>		
FY09		7,357.05
FY10	27.27	188,217.71
FY11	42.47	197,458.36
<b>Total:</b>		393,033.12
<b>Supervision/ICR</b>		
FY12	7.28	35,557.86
FY13	1.26	4,617.65
<b>Total:</b>		40,175.51

**Task Team Members**

<b>Names</b>	<b>Title</b>	<b>Unit</b>	<b>Responsibility/ Specialty</b>
<b>Lending</b>			
Melis U. Guven	Senior Social Protection Economist	AFTSE	Task Team Leader
Daniel Dulitzky	Sector Manager	ECSH1	Task Team Leader Sector Manager
Lorena Kostallari	Senior Operation Officer	ECSH1	Task Team Leader
Erjon Luci	Economist	ECSP2	Economist
Elda Hafizi	Program Assistant	ECCAL	Program Assistant
Armin Fidler	Senior Advisor	HDNHE	Technical Specialist
Enkelejda Karaj	Program Assistant	ECCAL	Program Assistant
Emil Tesliuc	Economist	ECSH3	
Borko Handjinski	Country Economist	ECSP2	Economist
Manuel Salazar	Senior Social Protection Specialist	AFTSP	Technical Specialist
Jesko Hentschel	Sector Director, SASHD	SASHD	Sector Manager
Margaret Png	Lead Counsel	LEGEM	Legal Specialist
Katerina Timina	Program Assistant	ECSH4	Program Assistant
Caterina Ruggeri Laderchi	Senior Economist	ECSP3	Economist
Lewis Hawke	Sr. Financial Management Specialist	ECSP3	Financial Specialist
Zurab Sajaia	Economist	DECCT	Economist
Ramya Sundaram	Senior Economist	ECSH4	Economist
Gordon Betcherman	Consultant	DECWD	Consultant
Reink Prins	Consultant		Consultant
Ilene Zeitzer	Consultant		Consultant
Dan Finn	Consultant	MNSHD	Consultant
Sarojini Hirshleifer	Consultant		Consultant
Gordon Betcherman	Consultant	DECWD	Consultant
Natsuko Kiso Nozaki	Consultant		Consultant
Alexandru Cojocaru	Consultant	ECSP3	Consultant
Ida Muhoho	Consultant	ECSP3	Consultant
Florian Tomini	Consultant		Consultant
<b>Supervision/ICR</b>			
Melis U. Guven	Senior Social Protection Economist	AFTSE	Task Team Leader

<b>Names</b>	<b>Title</b>	<b>Unit</b>	<b>Responsibility/ Specialty</b>
Daniel Dulitzky	Sector Manager	ECSH1	Task Team Leader Sector Manager
Lorena Kostallari	Senior Operation Officer	ECSH1	Task Team Leader
Irina A. Nikolic	Health Specialist	HDNHE	ICR Author/ ICR Task Team Leader

## Annex B. Basic Data Sheet for Health System Modernization Project (P082814)

### HEALTH SYSTEM MODERNIZATION PROJECT (P082814)

#### Key Project Data (amounts in US\$ million)

	Appraisal estimate	Actual or current estimate	Actual as % of appraisal estimate
Total project costs	19.11	19.00	99.40
Loan amount	15.40	14.50	97.70
Cofinancing	1.61	1.61	100.00
Cancellation	0.00	1.10	0.00

#### Cumulative Estimated and Actual Disbursements

	<i>FY07</i>	<i>FY08</i>	<i>FY09</i>	<i>FY10</i>	<i>FY11</i>	<i>FY12</i>	<i>FY13</i>
Appraisal estimate (US\$M)	1.61	6.27	10.86	13.89	15.40	15.40	15.40
Actual (US\$M)	0.50	1.04	3.31	6.36	10.32	12.22	14.50
Actual as % of appraisal	31.05	16.58	30.47	45.78	67.01	79.35	94.15
Date of final disbursement: 10/15/2012							

#### Project Dates

	Original	Actual
Initiating memorandum	04/05/2004	02/24/2005
Negotiations	02/06/2006	02/06/2006
Board approval	04/04/2005	03/14/2006
Signing	03/20/2005	04/22/2006
Effectiveness	09/07/2006	09/07/2006
Closing date	09/30/2010	06/30/2012

#### Staff Time and Cost

Stage of Project Cycle	Staff Time and Cost (Bank Budget Only)	
<b>Lending</b>	No. of staff weeks	US\$ Thousands (including travel and consultants costs)
FY04	73.78	318,004.15
FY05	30.32	122,962.21
FY06	3.87	131,864.33
<b>Total:</b>	<b>137.97</b>	<b>572,870.69</b>

<b>Supervision/ICR</b>		
FY06	1.35	10,370.62
FY07	25.39	77,512.16
FY08	30.69	118,497.31
FY09	35.09	125,930.46
FY10	26.68	58,067.94
FY11	30.94	106,702.50
FY12	21.74	62,552.52
FY13	13.26	36,209.68
<b>Total:</b>	<b>185.14</b>	<b>598,843.19</b>

### **Mission Data**

<b>Names</b>	<b>Title</b>	<b>Unit</b>
<b>Lending</b>		
Jan Bultman	Lead Health Specialist	ECSHD
Olav Rex Christensen	Senior Public Finance Specialist	HDNED
Dominic S. Haazen	Lead Health Policy Specialist	AFTHW
Monika Huppi	Manager	IEGPS
Lorena Kostallari	Senior Operations Officer	ECSH1
Carmen F. Laurente	Senior Program Assistant	ECSHD
Florian Tomini	Consultant	ECSHD
Anna L Wielogorska	Senior Procurement Specialist	EASRP
<b>Supervision/ICR</b>		
Dominic S. Haazen	Lead Health Policy Specialist	AFTHW
Caryn Bredenkamp	Economist (Health)	HDNHE
Jan Bultman	Lead Health Specialist	ECSHD
Nicholay Chistyakov	Senior Finance Officer	CTRLN
Olav Rex Christensen	Senior Public Finance Specialist	HDNED
Elona Gjika	Financial Management Specialist	ECSOQ
Elda Hafizi	Program Assistant	ECCAL
Lorena Kostallari	Senior Operations Officer	ECSH1
Carmen F. Laurente	Senior Program Assistant	ECSHD
Belita Manka	Counsel	LEGOP
Jasna Mestnik	Finance Analyst	CTRLA

<b>Names</b>	<b>Title</b>	<b>Unit</b>
Karina Mostipan	Senior Procurement Specialist	ECSO2
Wezi Marianne Msisha	Health Specialist	ECSH1
Imelda Mueller	Operations Analyst	ECSH2
Benedicta T. Oliveros-Miranda	Procurement Analyst	ECSO2
Kirsten Burghardt Propst	Senior Counsel	LEGLE
Pia Helene Schneider	Lead Evaluation Officer	IEGPS
Katerina Timina	Program Assistant	ECSHD

## **Annex C. List of Persons Met**

### **Government of Albania**

#### *Ministry of Finance*

- Erion Luci, Deputy Minister of Finance (since September 2013)

### **Health Sector**

#### *Ministry of Health*

##### *Central Level*

- HE Ilir Beqaj, Minister of Health (since September 2013)
- Milva Ekonomi, Deputy Minister of Health (since September 2013)
- Saimir Kadiu, Director of Economic and Financial Planning Department and HSMP Project Director
- Petro Mersini, Head of Hospital Care Department
- Gazmend Betja, Director of Public Health Department
- Erol Como, Head of Primary Health Care Sector

##### *Region of Durrës*

- Kristo Huta, Director, Directorate of Primary Health Care

##### *Region of Elbasan*

- Ilda Mano, Technical Deputy Director, Directorate of Primary Health Care

##### *District of Shkodra*

- Delegation from Shkodra Health District, presenting their analysis of services performance at the November 20, 2013 Conference on Quality, held in Tirana and sponsored by the National Center of Quality, Safety, and Accreditation of Health Institutions

#### *Health Insurance Institute*

##### *Central Level*

- Astrit Beci, General Director (since September 2013)
- Albana Adhami, Medical Adviser, National Health Insurance Fund
- Laureta Mano, Director of Legal Department, National Health Insurance Fund
- Rudina Mazniku, Director of Hospital Care, National Health Insurance Fund
- Aleksander Haxhi, Head of Policy Development Sector, Hospital Department, National Health Insurance Fund

- Naun Sinani, Head of Sector, Hospital Service Department, National Health Insurance Fund
- Miranda Bleta, Head of IT Infrastructure and Network Administration, National Health Insurance Fund

***Region of Durrës***

- Ilda Ramadani, Deputy Director, Regional Directorate of Health Insurance

***Region of Elbasan***

- Kastriot Belshi, Director, Regional Directorate of Health Insurance
- Merita Brica, Deputy Director, Regional Directorate of Health Insurance
- Eduart Kepaci, Head of IT/Statistics Sector, Regional Directorate of Health Insurance
- Dallendyshe Hoda, PHC Sector Economist, Regional Directorate of Health Insurance
- Altin Kernuti, Head of Hospital Sector, Regional Directorate of Health Insurance
- Lavdie Shqarri, Specialist Doctor, Regional Directorate of Health Insurance

***National Center of Quality, Safety and Accreditation of Health Institutions***

- Isuf Kalo, Director, National Centre of Quality, Safety and Accreditation of Health Institutions (fonder and incumbent since 2005)

***Public Health Facilities***

***Tirana***

- Arben Ura, Chief of Investment Department, Tirana University Hospital Center
- Artanca Collaku, Director, Primary Health Care Center no. 4 (Tirana)
- Alfred Lulo, Director, Primary Health Care Center no. 8 (Tirana)

***Durrës Region***

- Tauland Baku, Director, Durrës Regional Hospital
- Attending Physician, Primary Health Care Center attached to Regional Office of Ministry of Health

***Institute of Public Health***

- Genc Burazeri, Deputy Director

**Social Assistance Sector**

***Ministry of Social Welfare and Youth***

***Central Level***

- HE Erion Veliaj, Minister of Social Welfare and Youth (since September 2013)



- Bardhylka Kospiri, Deputy Minister of Social Welfare and Youth (since September 2013)
- Kastriot Sulka, former Deputy Minister of Labor, Social Welfare and Equal Opportunities (official Social Sector DPL counterpart)
- Alfred Nurja, Chief of Cabinet, Ministry of Social Welfare and Youth (since September 2013)
- Enkelejd Musabelliu, Adviser to the Minister, Ministry of Social Welfare and Youth (since September 2013)
- Denada Seferi, Director of Social Services and Social Assistance Department, Ministry of Social Welfare and Youth
- Etleva Zeqja, Head of Sector, Social Services and Social Assistance Department, Ministry of Social Welfare and Youth
- Ilda Bozo, Head of Monitoring and Evaluation Sector, Ministry of Social Welfare and Youth

#### *Region of Durrës*

- Dorian Hatibi, Director, Regional Directorate of State Social Service
- Edlira Ndreu, Physician, Regional Directorate of State Social Service
- Gezim Pajo, Inspector, Regional Directorate of State Social Service
- Denis Risto, Inspector, Regional Directorate of State Social Service

#### *Region of Elbasan*

- Marsida Haxhiu, Director, Regional Directorate of State Social Service
- Financial Management Specialist, Regional Directorate of State Social Service

### **Professional Organizations and Civil Society**

- Shaqir Krasta, Secretary General, National Council, Order of Physicians of Albania
- Sabri Skenderi, Nurse, Head, Albanian Order of Nurses
- Albert Gjoka, Head, Health Journalists Club
- Lorina Mixha, Journalist at Top Media, covering health and social welfare issues
- Eglantina Bardhi, Health Journalist and Civil Society Activist

### **World Bank**

- Kseniya Lvovsky, Former Country Manager, Albania, 2010-2013
- Daniel Dulitzky, Sector Manager, ECA, Health and Nutrition, March 2011–Present, (Task Team Leader of Social Sector DPL during Preparation)

- Lorena Kostallari, Task Team Leader (Health System Modernization Project and Social Sector DPL)
- Dominic Haazen, former Task Team Leader (Health System Modernization Project)
- Pia Schneider, former Task Team Leader (Health System Modernization Project)
- Monika Huppi, former Health Sector Leader and author of Health Policy Note (2006).
- Melis Guven, Senior Social Protection Specialist, ECA, 2008-2012 (Team member, then Task Team Leader of Social Sector DPL until 2012)
- Aylin Isik-Dikmelik, Senior Economist, ECSH3 (Task Team Leader of Social Assistance Modernization Project)

### **Other Development Partners and Independent Experts**

- Vasil Miho, Acting Head of Office, Albania Country Office, World Health Organization, Albania Office
- Zamira Sinoimeri, Senior Health Policy Adviser, USAID ‘Enabling Equitable Health Reforms’ Project (former Deputy Minister of Health, and formerly with WHO)
- Altin Azisllari, Independent HIS Expert (former USAID ‘Pro Shendetit’ Project HMIS component head)
- Anne Savary, Deputy Director of Cooperation, Swiss Agency for Development and Cooperation (SDC), Albania Office
- Sokol Haxhiu, National Program Officer, Swiss Agency for Development and Cooperation (SDC), Albania Office

## Annex D. Previous Bank Support to Health and Social Protection in Albania

Sector/Projects	Approved	Closed	Credit (Total Cost) (US\$m)	Objectives (taken from abstract in Bank's system)
<b>Health</b>				
Health Services Rehabilitation Project P008253	11/08/94	03/31/01	12.4 (16.0)	To help prevent deterioration in health status during the economic transition by improving the quality of basic preventive and curative health care through upgrading primary and secondary facilities, improving skills of providers and building central and district capacity to manage resources and implement reforms. <i>Outcome: Satisfactory</i>
Health System Recovery and Development Project P045312	05/12/98	01/31/05	17.0 (28.0)	To establish/strengthen institutional and human resource capacities for an effective and sustainable health sector; and improve the accessibility, quality and efficiency of essential health services, in fulfillment of a precondition for sustained improvements in health status. <i>Outcome: Moderately Unsatisfactory</i>
Health System Modernization Project P082814	06/14/06	06/30/12	15.4 (19.1)	To improve (i) the capacity of the Ministry of Health and Health Insurance Institute to effectively formulate and implement health policies and reforms in provider payments, monitoring and quality assurance; (ii) the access to and quality of primary health care services, with an emphasis on those in poor and under-served areas; and (iii) governance and management in the hospital sector. <i>Outcome: Moderately Unsatisfactory</i>
Avian Influenza Control & Human Pandemic Preparedness and Response P100273	06/27/06	12/31/10	5.0 (6.0)	To strengthen the country's capacity to prevent the spread of avian influenza among poultry, to prevent the transmission of avian influenza from birds to other animals and humans, and to prepare for a potential pandemic of Avian Flu transmissible between humans. <i>Outcome: Moderately Satisfactory</i>

<b>Social Protection</b>				
Social Safety Net P008265	09/14/93	08/31/99	5.5 (6.2)	To develop policy to consolidate basic social insurance and social assistance programs reform; strengthen institutions responsible for planning and management of cash benefits; and strengthen training, research and statistical institutions to support social policy formation and implementation. To support Albania in restructuring the social safety net and bringing social policies in line with a decentralized democratic society and a transitional economy. Includes social insurance reform and social assistance development. <i>Outcome: Satisfactory</i>
Social Services Delivery Project P055383	06/07/01	03/30/13	10.0 (15.0)	To improve standards of living for the poor and vulnerable population groups by increasing their access to well-targeted and effective social care services; assisting the Government to develop, monitor and evaluate more effective social policy; and improving capacity for planning, managing and delivering social care services with increased involvement of local governments, communities, and civil society. <i>Outcome: Moderately Satisfactory</i>
Social Service Delivery Project Additional Financing P107382	03/17/09	N/A	5.0	To improve the standards of living of poor and vulnerable population groups in Albania by: (a) increasing their access to effective social care services; (b) assisting the Government to develop effective social care policy and improve its capacity for delivery and monitoring of social care services; and (c) improving the efficiency and effectiveness of the pension system in Albania. <i>Outcome: Moderately Satisfactory</i>

Social Sector Reform Development Policy Loan P116937	04/28/11	04/30/2012	25.0	To support policy changes to improve the effectiveness of social safety nets, and enhance efficiency and equity of health spending, in a fiscally sustainable environment. The DPL will also enhance the transparency and accountability by supporting policies to improve the administration of social assistance programs and promoting the use of systematic formulas to allocate resources in selected social programs and services. This DPL supports the adoption of broad policy changes in social programs through revised legislation or other Government decisions. It is part of a package that combines policy and institutional reforms with support for enhanced implementation capacity through investment lending. <i>Outcome: Moderately Satisfactory</i>
Social Assistance Modernization Project P122233	04/03/12	06/30/2017	50.0 (244.5)	To support country's implementation of reforms to improve the equity and efficiency of its social assistance programs. <i>Under Implementation</i>

<b>Poverty Reduction</b>				
PRSC1 P069935	06/20/02	6/30/03	20.0 (20.0)	To develop and implement fiscally sustainable policies within the framework of Growth and Poverty Reduction Strategy that supports a higher quality of life, especially for the poor, consistent with the country's overall growth strategy. This operation supports: more effective and efficient policy formulation and implementation, improved access to social services and better targeting of scarce fiscal resources to those most in need, and policies conducive to sustained growth. <i>Outcome: Satisfactory</i>
PRSC2 P077739	07/10/03	12/31/04	18.0 (18.0)	To develop and implement fiscally sustainable policies within the framework of the Government's strategy (NSSED) supporting a higher quality of life (especially for the poor), and consistent with and supportive the overall growth strategy. This operation will support more effective and efficient policy formulation and implementation, improved access to social services and better targeting of scarce fiscal resources to those most in need. <i>Outcome: Moderately Satisfactory</i>
PRSC3 P083337	12/07/04	12/31/05	10.0 (10.0)	To consolidate reforms in public administration, public expenditure management and accountability, and social service delivery, supporting the country's efforts to increase accountability, responsibility, effectiveness. Reforms would help increase professionalism and the performance of social sector line agencies and the social insurance institute thus improving capacity to regulate, monitor and delivery services. <i>Outcome: Satisfactory</i>

## Annex E. HSMP Performance Indicators

**Table E.1. Relevance of Design -- Analysis of Restructurings – Indicators and Activities**

Indicators (4/22/10 restructuring)	Activities
<b>PDO #1 Improve the physical and financial access to, and use of high quality primary health care services</b> , with an emphasis on those in poor and under-served areas, as well as to diminish the unnecessary use of secondary and tertiary care facilities	
<i>Added:</i>	
Health facilities (PHC centers) renovated and equipped: target 2200 PHC centers furnished w/ med eq	Purchasing of specialized medical equipment (mammographs and autoclaves, e.g.) for Albania's main hospitals to support increasing capacity in (a) diagnosis of breast cancer through purchasing of mammography equipment for four main hospitals; and (b) treatment of hospital waste by the provision of autoclaves for seven main hospitals. ICR noted that this supported strengthening of the primary-secondary care interface. The purchase of sophisticated equipment for Tirana hospital was also included: cardiology, pediatric surgery. 4/2010
Children immunized	Purchasing of medical equipment for the regional hospitals based on the rationalization plan for hospitals in support of strengthening regional hospital capacity. 4/2010
Pregnant women receiving antenatal care during visit to a health provider	National Communication Strategy: the design and roll-out of a communication strategy for the health sector. 4/2010
Improved capacity of all regional hospitals through supply of essential medical equipment (target: functional in all regional hospitals)	
Strengthened hospital capacity to diagnose breast cancer and dispose of hospital waste (through purchasing of autoclaves and mammography equipment)	
<i>Dropped:</i>	
Primary care physician practice patterns are consistent with quality training, confirmed by the 70 percent compliance with disseminated clinical practice guidelines and by referrals to secondary and tertiary care consistent with these guidelines	Grant facility to fund proposals from primary care providers in support of quality of care and a continuum of care improvement initiatives. Government has not shown due interest in implementing this activity (no step has been undertaken for establishing the required unit responsible for grant fiduciary responsibilities, no grant procedures were defined (eligibility and selection criteria), no public information campaign, promotion sensitization activities were carried out, etc.). Decision thus made to reallocate proceeds to other priorities. 4/2010
Increase of 30 percent in the proportion of identified medical conditions that are cared for w/in a PHC setting	
<b>PDO #2 Improve the Recipient's capacity</b> (to increase the effectiveness of the MoH and the HII) <b>to formulate and implement health policies and reforms</b> (in provider payments and health system performance) <b>in the health sector</b>	
<i>Added:</i>	
Health Sector Strategy developed and approved	Finance the production of health cards for ages 0-16 (not covered by general ID card) based on GoA decision to finance from its own budget the health cards and general identification cards for the population over 16 years). 4/2010
Licensing and Accreditation established	

(2010) and functioning (2012)	
<b><i>Dropped:</i></b>	
HII is able to live within its budget w/out additional Ministry of Finance funding	Procurement of software dropped, but procurement of hardware will still continue to be financed under the project, as planned. This is due to significant delays in procurement of software (main reason being lack of decision from HII on key directions for developing the information system for HII). 9/2011
Over 90 percent of total publicly financed health expenditures flow through active purchasing methods	Facilitation of registration of the population with the HII and enrollment with a primary care physician. Dropped because design of health info system suffered from continuous delays. 9/2011
Revised payment methods in primary, specialist and hospital care increase efficiency and effectiveness, measured by: <ul style="list-style-type: none"> <li>• 10 percent reduction in admission rate</li> <li>• 10 percent lower average length of stay</li> </ul>	
MoH and HIF policy units provide timely support for policy development	
Effective continuing medical education (CME) catering to all GPs and FPs and delivering 40 hours of training per year per physician	
All physicians are licensed and a first cohort of 20 percent of all physicians has gone through the re-validation (relicensing) procedure.	
All hospitals have been surveyed according to the accreditation standards and have written quality improvement plans to achieve the standards.	
<b>PDO #3 Improve hospital governance and management</b>	
<b><i>Added:</i></b>	
Privatization plan for non-medical activities in all regional hospitals developed and presented to Govt for further decision	Privatization of all non-medical activities in the regional hospitals: technical assistance to MoH in preparing and implementing this in all regional hospitals in the country, as a part of the PPP framework. 4/2010
Rationalization plan for hospitals developed and approved by the Government	Testing of the hospitalization rationalization strategy on a pilot basis in two selected districts through the provision of consultancy services. 9/2011
Number of hospitals' key administration staff trained: 180	
<b><i>Dropped:</i></b>	
Based on agreed key performance indicators, hospitals using new governance approaches perform better than those who do not.	
Hospital performance using an agreed set of key indicators, and comparisons between hospitals being done	
Number of hospitals where board governance structures are successfully piloted	

Table E.2. Health System Modernization Project: Objectives and Indicators Worksheet

Original <sup>57</sup>	Restructuring Paper (April 22, 2010) <i>(baselines updated in this Paper; targets set for new closing date established in the Paper: 3/31/2012)</i> Note: These indicators were recorded in the March 2009 Aid-memoire and were monitored from that point on.	Actuals
<b>PDO #1: To improve the physical and financial access to, and use of, high quality primary health care services, with an emphasis on those in poor and under-served areas, as well as to diminish the unnecessary use of secondary and tertiary care facilities</b>		
<b>Project Outcome Indicators/Key Performance Indicators</b>		
<ul style="list-style-type: none"> <li>At least 70 percent of the population is enrolled with a primary health care provider...</li> <li>...and use him/her as their first source of health care</li> </ul>	<p><b>Original KPI Maintained:</b> At least 70 percent of the population is enrolled with a PHC provider... and use him/her as their first source of health care <b>Baseline:</b> 0 <b>Target:</b> 70 percent</p>	<p><b>Data not clear:</b> The ICR reports 70 percent, based on HII administrative data and preliminary results of the Population and Housing Census 2011 (for population data). Preliminary data from LSMS 2012 show 62 percent. However, INSTAT notes that the question on coverage and registration is not clear and they believe the level to be higher. It is still unclear to IEG (unable to obtain the LSMS) what are the numerator and denominator, methodology for calculating, regional/district breakdown, among others. It is difficult to reconcile this with HII Annual Report 2012 data that note 53 percent of the population to be covered by insurance and enrolled with a primary health physician.</p>
<ul style="list-style-type: none"> <li>Reduced percentage of households who do not seek necessary health care because they cannot afford it....</li> </ul> <p><b>Baseline:</b> not specified <b>Target:</b> 50 percent</p> <ul style="list-style-type: none"> <li>...and reduced share of household expenditure for primary care services</li> </ul> <p><b>Baseline:</b> not specified <b>Target:</b> 50 percent</p>	<p><b>Original KPI Maintained:</b> Reduced percentage of households who do not seek necessary health care because they cannot afford it... and reduced share of household expenditure for primary care services <b>Baseline:</b> 28.9 percent <b>Target:</b> 20 percent <i>(not clear which sub-indicator the baseline and target data are addressing)</i></p>	<p><b>Data not clear.</b> The ICR reports that the percentage of the population avoiding care-seeking behavior due to financial factors decreased from 27 percent in 2005 (LSMS) to 19 percent in 2012 (i.e., a 30 percent reduction). The TTL has promised to send IEG the two surveys from which the 2005 and 2012 data were drawn so that IEG can assess the comparability of the two sets of data and the methods for calculations. But those have not been received. This is inconsistent with USAID's survey of consumers (2013).</p>
<ul style="list-style-type: none"> <li>Increased patient satisfaction with PHC treatment...</li> </ul> <p><b>Baseline:</b> not specified</p>	<p><b>Maintained:</b> Increased patient satisfaction with PHC treatment</p>	<p><b>Inconsistent data:</b> The ICR reports 98 percent. Data is derived from sector surveys and the MoH. IEG has not been</p>

<sup>57</sup> PDOs taken from PAD statement (p. 6) and DCA statement Annex 1; KPIs taken from PAD p. 6; intermediate outcome indicators taken from PAD Results Framework, Annex 3, p. 24.

<p><b>Target:</b> an increase of 30 percent over baseline, as measured by two subsequent population surveys with identical questionnaires (Component 2 indicator)</p> <ul style="list-style-type: none"> <li>...and improved outcomes for defined health conditions</li> </ul>	<p><b>Baseline:</b> 88.4 percent <b>Target:</b> 100 percent</p> <p><b>Maintained:</b> ...and improved outcomes for defined health conditions</p>	<p>successful in accessing the sources of this data to gain a better appreciation of the survey question(s), sample, methodology, etc. This data is highly inconsistent with a USAID survey of consumers' perspectives on the health care system (USAID, 2013) and with IEG's mission findings.</p> <p><b>Achievement unknown:</b> The ICR reports that there is no strong evidence to suggest improved outcomes for defined health conditions; and IEG corroborates this finding.</p>
	<p><b>Added:</b> Number of visits per capita per year to the primary health care centers <b>Baseline:</b> 1.6 <b>Target:</b> 2.0</p>	<p><b>Target almost achieved:</b> The ICR reports the achievement of 2.0 visits, estimated using HII data, refreshed with the 2011 census data on population. HII/MoH data (also reported in the ICR) of 5.754,452 visits in 2011 translates to 1.8 visits per capita using the World Bank World Development Indicator estimate for Albania's population size for 2011.</p>
<b>Intermediate Outcome Indicators (Component 2)</b>		
<i>Population is registered with primary health care providers</i>		
<ul style="list-style-type: none"> <li>70 percent of the population per district/region is enrolled with a specific physician (or PHC center)</li> </ul>	<b>Duplicate of KPI</b>	
<i>Population has better access to PHC services</i>		
<ul style="list-style-type: none"> <li>Average out-of-pocket payment for PHC services is reduced by 50 percent</li> </ul>	<b>Dropped</b>	Not monitored.
<ul style="list-style-type: none"> <li>Avoiding care-seeking behavior due to financial factors has reduced by 50 percent</li> </ul>	<b>Duplicate of KPI</b>	
<i>Quality is improved</i>		
<ul style="list-style-type: none"> <li>Training has been completed...</li> <li>...and primary care physician practice patterns are consistent with this training, confirmed by the 70 percent compliance with disseminated clinical practice guidelines and by referrals to secondary and tertiary care, consistent with these guidelines</li> </ul>	<p><b>Reworded:</b> Quality training for primary health care (provided by USAID in six of twelve regions) scaled up to remaining six regions <b>Baseline:</b> 0 <b>Target:</b> 6</p> <p><b>Dropped</b></p>	<p><b>Target partially achieved.</b> Training expanded to three additional regions (Tirana, Durres, and Elbasan) or 60 percent of the population in the six targeted regions.</p> <p>Not monitored.</p>



	<p><b>Added:</b> Health personnel receiving training  <b>Baseline:</b> 0  <b>Target:</b> 560</p>	<p><b>Target achieved.</b> 560 health personnel received training.</p>
<ul style="list-style-type: none"> <li>• Patient/physician satisfaction with PHC has increased by 30 percent according to two subsequent population surveys with identical questionnaires</li> </ul>	<p><i>Duplicate of KPI</i></p>	
<p><i>PHC is used for a majority of health services needs</i></p>		
<ul style="list-style-type: none"> <li>• Increase of 30 percent in the proportion of identified medical conditions that are cared for within a PHC setting</li> </ul>	<p><b>Dropped</b></p>	<p>Not monitored</p>
	<p><b>Added:</b> Health facilities (PHC centers) renovated and equipped  <b>Baseline:</b> 0  <b>Target:</b> 2200 PHC centers furnished with medical equipment</p>	<p><b>Data unclear.</b> The ICR reports that 2200 PHC facilities were “constructed, renovated, and/or equipped,” but there are only 421 PHC centers in the country and there was no construction envisaged under the project. The TTL and Project Director later clarified that, in addition to the 421 health centers, the other facilities equipped were “ambulances” (small rural health outposts). There is no information on geographic breakdown of this support to monitor intended attention to underserved areas and/or improve physical coverage.</p>
	<p><b>Added:</b> Children immunized  <b>Baseline:</b> 220,000  <b>Target:</b> 240,000</p>	<p><b>Indicator statement unclear.</b> The ICR reports that the share of children immunized remained high at 94 percent in 2010 and 95 percent in 2012. Baseline and target values are expressed as proportions. This was added as a Bank “core indicator” but it is not clear whether “children immunized” means fully immunized, any immunization, any age... The TTL has asked the Project Director to confirm that this indicator means children under five, who are fully immunized.</p>
	<p><b>Added:</b> Pregnant women receiving antenatal care during a visit to a health provider  <b>Baseline:</b> 33,000  <b>Target:</b> 36,000</p>	<p><b>Indicator statement unclear.</b> The ICR reports that the percent of pregnant women receiving antenatal care during a visit to a health provider increased from 95 to 97 percent. Initial baseline and target were based on data from the last census. Due to a significant reduction in fertility, the total annual number of births is currently estimated to be between 33,000 and 34,000. The indicator as it is stated in the restructuring and reported on in the ICR is poorly stated, conveying that the</p>

		denominator is pregnant women visiting the health center. But the TTL says that the numerator is pregnant women visiting the health center and the denominator is all pregnant women. The project director has been asked to clarify and provide any data updates.
<i>(Implicit intermediate outcome added during April 2010 restructuring: Improved capacity of hospitals to provide quality referral services from PHC level)</i>		
	<b>Add:</b> Improved capacity of all regional hospitals through supply of essential medical equipment <b>Target:</b> Medical equipment functional in all regional hospitals	<b>Target partially achieved.</b> Some of the equipment was not supplied due to misprocurement.
	<b>Added:</b> Strengthened hospital capacity to diagnose breast cancer and dispose of hospital waste (through purchasing of autoclaves and mammography equipment) <b>Baseline:</b> 0 <b>Target:</b> autoclaves functioning in 7 main hospitals; and 4 key hospitals equipped with mammography	<b>Target partially achieved.</b> Autoclave equipment functioning in 7 hospitals; and 4 hospitals equipped with mammography equipment.
<b>**No indicators/measurement of effect on poor/vulnerable populations and areas, despite its emphasis in the PAD</b>		
<b>PDO #2: To improve the Recipient's capacity (to increase the effectiveness of the MoH and the HII) to formulate and implement health policies and reforms (in provider payments and health system performance) in the health sector</b>		
<b>Project Outcome Indicators/Key Performance Indicators</b>		
<ul style="list-style-type: none"> <li>HII is able to live within its budget without additional Ministry of Finance funding</li> </ul>	<b>Dropped</b>	Not accurately or consistently monitored.
<b>Intermediate Outcome Indicators (Component 1)</b>		
<i>MoH and HIF are capable of developing and modifying health policies, effectively monitoring health system performance and effectively purchasing and monitoring health services on behalf of the population of Albania</i>		
<ul style="list-style-type: none"> <li>Over 90 percent of total publicly financed health expenditures flow through active purchasing methods</li> </ul>	<b>Dropped</b>	Not monitored.
<ul style="list-style-type: none"> <li>Revised payment methods in primary, specialist and hospital care increase efficiency and effectiveness, measured by: <ul style="list-style-type: none"> <li>10 percent reduction in admission rate</li> </ul> </li> </ul>	<b>Dropped</b>	<b>Unreliable data.</b> The ICR reported that the hospital admission rate was reduced by 1 percent. It was clarified by the TTL that since this is a dropped indicator, reporting was based only on some

		administrative data, which are not that reliable.
<ul style="list-style-type: none"> <li>○ 10 percent lower average length of stay (ALOS)</li> </ul>	<b>Dropped</b>	<b>Unreliable data.</b> The ICR reported that ALOS was reduced by 9 percent. The TTL indicates that, as above, this indicator was dropped and reporting is based on unreliable data.
<ul style="list-style-type: none"> <li>• An agreed set of monitoring data is available on an ongoing basis with monthly/quarterly performance reports produced</li> </ul>	<p><b>Reworded:</b> An agreed set of monitoring data is used for M&amp;E and reported (based on the agreed 145 indicators)  <b>Baseline:</b> No data agreed  <b>Target:</b> Indicators produced monthly</p>	<b>Target partially achieved.</b> A set of monitoring data including 145 indicators was agreed and approved by the MoH. Reporting has started based on 60 defined indicators. MoH has obtained support from USAID to further develop the established system.
<ul style="list-style-type: none"> <li>• MoH and HIF policy units provide timely support for policy development</li> </ul>	<b>Dropped</b>	Not monitored.
<ul style="list-style-type: none"> <li>• New Clinical Practice Guidelines developed and implemented for (unspecified) priority diseases (<i>quality</i>)</li> </ul>	<p><b>Reworded:</b> New Clinical Practice Guidelines developed for 6 priority diseases and implemented in 12 regions  <b>Baseline:</b> No CPGs in place; 5 prepared by 2010  <b>Target:</b> 6 CPGs developed and implemented in 12 regions</p>	<b>Target partially achieved.</b> Five CPGs were prepared, but their application in the health facilities has not been systematically monitored.
<ul style="list-style-type: none"> <li>• Effective continuing medical education (CME) catering to all GPs and FPs and delivering 40 hours of training per year per physician (<i>quality</i>)</li> </ul>	<b>Dropped</b>	Not monitored.
<ul style="list-style-type: none"> <li>• All physicians are licensed and a first cohort of 20 percent of all physicians has gone through the re-validation (re-licensing) procedure (<i>quality</i>)</li> </ul>	<b>Dropped</b>	Not monitored.
<ul style="list-style-type: none"> <li>• All hospitals have been surveyed according to the accreditation standards and have written quality improvement plans to achieve the standards (<i>quality</i>)</li> </ul>	<b>Dropped</b>	Not monitored.
<ul style="list-style-type: none"> <li>• Health technology assessment function established and used in decision-making on the positive list of drugs and investments in hospitals</li> </ul>	<p><b>Reworded:</b> Health technology assessment function established and used in decision-making for benefit package  <b>Baseline:</b> No assessment in place  <b>Target:</b> Assessment</p>	<b>Target achieved.</b> Assessment completed and being used.

	completed (2010), and used in decision-making for the benefit package (2012)	
	<b>Added:</b> Health Sector Strategy developed and approved <b>Baseline:</b> No strategy in place <b>Target:</b> Strategy developed and approved	<b>Target achieved.</b> Health Sector Strategy was developed and approved by MoH
	<b>Added:</b> Licensing and Accreditation established and functioning <b>Baseline:</b> No system of licensing in place <b>Target:</b> Licensing and Accreditation unit established (2010) and fully functional (2012)	<b>Target achieved.</b> Licensing and accreditation unit established and fully functioning.
<b>PDO #3: To improve hospital governance and management</b>		
<b>Project Outcome Indicators/Key Performance Indicators</b>		
<ul style="list-style-type: none"> <li>Based on agreed key performance indicators, hospitals using new governance approaches perform better than those who do not</li> </ul>	<b>Dropped</b>	Not accurately or consistently monitored.
<b>Intermediate Outcome Indicators (Component 3)</b>		
<i>Improved management of hospitals and piloting efforts for increased involvement by stakeholders in the governance of these facilities</i>		
<ul style="list-style-type: none"> <li>Hospital performance using an agreed set of key indicators, and comparisons between hospitals being done</li> </ul>	<b>Dropped</b>	Not monitored.
<ul style="list-style-type: none"> <li>Number of hospitals where board governance structures are successfully piloted</li> </ul>	<b>Dropped</b>	Not monitored.
	<b>Added:</b> Privatization plan for non-medical activities in all regional hospitals developed and presented to the Government for further decision <b>Baseline:</b> No plan exists <b>Target:</b> Privatization plan developed and presented to the Government for further decision	<b>Target achieved:</b> Privatization plan for non-medical activities in regional hospitals developed and presented to the Government.
	<b>Added:</b> Rationalization plan for hospitals developed and approved by the Government <b>Baseline:</b> No plan	<b>Target achieved.</b> Rationalization plan was developed and approved by the Government.

	<b>Target:</b> Plan developed and approved by MoH	
	<b>Added:</b> Number of hospitals' key administration staff trained <b>Baseline:</b> 0 <b>Target:</b> 180	<b>Target achieved:</b> 180

## Annex F. HSMP Financing and Use of IDA Credit

<b>Table F.1. Planned versus Actual Financing (US\$ million)</b>	<b>Planned</b>	<b>Actual</b>
IDA Credit	15.4	14.5
Government of Japan (PHRD)	1.6	1.6
Government of Albania	2.1	2.9
<b>Total</b>	<b>19.1</b>	<b>19.0</b>

<b>Table F.2. Planned versus Actual Disbursements by Disbursement Category (millions of SDRs)</b>				
Disbursement Category	Original Allocation	April 2010 Restructuring	September 2011 Restructuring	Actuals
(1) Goods other than goods under Parts A.3 and B.6 of the Project	1.12	0.69	0.32	0.26
(2) Goods under Part A.3 of the Project	1.95	2.05	1.52	1.33
(3) Goods under Part B.6 of the Project	2.19	4.80	5.50	5.29
(4) Consultants' services	1.70	2.50	2.50	2.41
(5) Training	0.67	0.08	0.08	0.06
(6) Unit Costs under Part B.1 of the Project	1.69	0.50	0	0
(7) Small Grants under Part B.7 of the Project	0.34	0	0	0
(8) Incremental Operating Costs	0.44	0.08	0.08	0.06
(9) Unallocated	0.60	0	0	0
	-	-		
<b>Total Disbursements</b>	<b>10.70</b>	<b>10.70</b>	<b>10.00</b>	<b>9.41</b>
Amount of Credit Cancelled	-	-	<b>0.70</b>	<b>1.29</b>
			<b>10.70</b>	<b>10.70</b>

## Annex G. Social Assistance Modernization Project (SAMP): An Overview

Social Assistance Modernization Project, Basic Data
<p><b>Objective:</b> To support Albania's implementation of reforms to improve equity and efficiency of its social assistance</p> <p><b>Components:</b></p> <ol style="list-style-type: none"> <li><b>1. <i>Strengthening the Implementation and Performance of Social Assistance Programs</i></b> (NE and disability, included) (with focus on the main reform areas: (a) program parameters (eligibility criteria and intake processes); (b) benefits administration (business processes, information management, payments mechanisms, and reporting and monitoring); and (c) oversight and controls.</li> <li><b>2. <i>Technical Assistance to Strengthen Implementation Capacity for Social Assistance Programs</i></b>, including: (a) revising program parameters for improved equity; (b) strengthening benefits administration for improved efficiency; and (c) promoting transparency with communications, monitoring and evaluation; and (d) project implementation support.</li> </ol> <p><b>Project Development Indicators:</b></p> <p><b><i>Improved Equity:</i></b></p> <ul style="list-style-type: none"> <li>• Coverage of the extreme poor by the NE program increases by 50 percent from the baseline (from 25 percent to at least 38 percent);</li> <li>• Targeting accuracy improves, as measured by an increase in the percentage of NE benefits going to the extreme poor (targeting accuracy increasing from 15 percent to at least 25 percent);</li> <li>• Share of disability assistance beneficiaries that report "no functional disability" is reduced (from current share of 14 percent as reported in 2011 PSIA Survey on Disability;</li> </ul> <p><b><i>Increased Efficiency:</i></b></p> <ul style="list-style-type: none"> <li>• MOLSA uses three-monthly performance management reports for policy-making purposes; such reports would be generated by automated MISs covering core monitoring indicators for NE and disability benefits;</li> <li>• Detection of error and fraud strengthened through the use of risk-based profiling tools; and (iii) remedy of error and fraud strengthened through enforcement of improved sanctions policy.</li> </ul> <p><b>Total Estimated Project Cost:</b> EUR 185.82 million, of which EUR 147.82 million financed by Government and EUR 38 million financed by IBRD.</p>
<p><i>Source:</i> Project Appraisal Document, Social Assistance Modernization Project (World Bank, March 7, 2012).</p>

## Annex H. Social Sector Reform DPL Performance Indicators

<b>Table H.1. Achievement of PDO#1: Policy Changes to Improve Social Safety Effectiveness</b>	
<b><i>Challenge #1: Strengthen mechanisms to allocate funds and select beneficiaries in the NE program</i></b>	
<b><i>Government Prior Action</i></b>	Passage of relevant legislation with the amendment to Law No. 9355 on Social Assistance and Services, approved by the Council of Ministers on January 19, 2011
<b><i>Result Achieved</i></b>	Adoption of this Law established the legal basis for revising eligibility criteria for NE by supporting changes to its resource allocation system to include poverty criterion in determining allocations of grants from central to local levels of the NE program and by defining household eligibility criteria based on a unified scoring formula.
<b><i>DPL Outcome Measurement</i></b>	<ul style="list-style-type: none"> <li>• Authorizing environment established for a more transparent and predictable block grant allocation on the basis of poverty indicators: <b><i>Achieved</i></b></li> <li>• Increased percentage of poor receiving means-based social assistance from 22 percent in 2008 to 30 percent in 2012: <b><i>Expected to be achieved</i></b> (current data show increase from 22 to 24.3 percent [preliminary LSMS data cited by TTL], but reform implementation under SAMP has not yet started. SAMP's support of pilot reforms, while somewhat delayed, is expected to culminate in the achievement of this target.</li> <li>• Increased share of benefits accruing to the poor from 42 percent in 2008 to 60 percent in 2013: <b><i>Expected to be achieved</i></b>. SAMP is supporting these activities, albeit with delays in implementation, linked in part to transition in Government. The target is expected to be achieved in another 1-2 years, following implementation of the pilot phase and subsequent nationwide reform implementation.</li> </ul>
<b><i>SAMP Support</i></b>	Development of institutional capacity to implement changes in targeting, including: revision of poverty estimates using 2011 Census Data; (ii) design of an allocation formula from MoLSAE to municipalities using poverty indicators; (iii) development of new means testing formula at the household level; and (iv) pilot testing of the revised formula.
<b><i>Challenge #2: Change the indexation formula of the disability benefits package program to control the share of resources allocated to this program, which is growing disproportionately</i></b>	
<b><i>Government Prior Action</i></b>	Enactment of legislation to this end through the Council of Ministers' Decision 602, 603 and 604 on July 23, 2010
<b><i>Result Achieved</i></b>	This legislation provides for the change in the indexation formula for disability benefits by linking the increases to inflation (vs. more rapidly rising minimum) thus containing the costs of disability benefits.
<b><i>DPL Outcome Measurement</i></b>	<ul style="list-style-type: none"> <li>• Savings realized in disability benefit spending of at least 5 percent of its budget by 2012. <b><i>Expected to be achieved in time and more precisely measured</i></b>. The ICR reports a 7 percent savings, but the baseline year and basis for calculation are not clear. The TTL notes that the 7 percent figure may have come from simulations prepared by the team some time ago. Expected reduction in the growth/number of beneficiaries will also contribute.</li> <li>• Number of disability beneficiaries as a percent of the population stabilized by 2014. <b><i>Expected to be achieved with ongoing support from SAMP, but not directly related to the DPL's support to changes in indexation of benefits</i></b>.</li> </ul>
<b><i>SAMP Support</i></b>	Under SAMP disbursements will be suspended if disability increases more than inflation, demonstrating emphasis on cost containment. Reform of disability under SAMP will address the increase in the number of beneficiaries through redesign of eligibility criteria, reduction of fraud, building MIS for disability. Disability reform more politically complex.
<b><i>Challenge #3: Introduce incentives for investing in human capital by providing an additional benefit linked to school enrollment and attendance for families with school age children</i></b>	
<b><i>Government Prior Action</i></b>	The Council of Ministers approved the amendment of Law No. 9355 on January 19, 2011, which provides for this bonus.
<b><i>Result Achieved</i></b>	While this provision has been legislatively enabled, the World Bank and the Government decided to postpone implementation of this reform until after the first phase of reforms has



	been implemented, due to capacity constraints and fiscal concerns. It is uncertain whether the new government will prioritize this measure in the current fiscal environment.
<b>DPL Outcome Measurement</b>	<ul style="list-style-type: none"> <li>Increased attendance of students from NE beneficiary families from 52 percent in 2010 to 70 percent in 2013. <i>Not likely to be achieved under the SAMP.</i></li> </ul>
<b>SAMP Support</b>	Implementation of the bonus for attendance through technical assistance to: (i) define the optimal level at which to apply bonus (primary, lower or upper secondary); and (ii) develop a mechanism to monitor compliance.
<b>Challenge #4: Initiate the process to create a unified registry of beneficiaries of social assistance programs</b>	
<b>Government Prior Action</b>	Amendment of Law 9355, approved by the Council of Ministers on January 19, 2011 to this end.
<b>Result Achieved</b>	This legislation mandates the creation of an automated national registry for applicants and beneficiaries of the social assistance program.
<b>SAMP Support</b>	Establishment of an automated information system for NE beneficiaries with a unique identification number linking social assistance beneficiaries with other programs is underway. Initial applications and cross-checks w/ other systems are currently being tested. Its pilot application will start in April.

<b>Table H.2. Achievement of PDO#2: Policy Changes to Enhance the Efficiency and Equity of Health Spending</b>	
<b>Challenge #5: Extend health insurance coverage to social assistance beneficiaries</b>	
<b>Government Prior Action</b>	Passage of the Law on Mandatory Insurance for Health Care, approved by the Council of Ministers on January 6, 2011, passed by Parliament on February 24, 2011.
<b>Result Achieved</b>	Adoption of this Law authorizes HII to extend coverage of health insurance to NE program beneficiaries and has established the principle of a defining a package of benefits, facilitating the estimation of the costs of this provision.
<b>DPL Outcome Measurement</b>	<ul style="list-style-type: none"> <li>100 percent of NE recipients receive health insurance. <i>Not likely to be achieved.</i> The Government has not yet fully implemented this reform, due to fiscal concerns. The newly elected Government has highlighted universal health coverage in its election campaign, which is expected to be approached through a tax-based financing scheme.</li> <li>Health spending as a share of household spending for the poor decreased by at least 5 percent. <i>Insufficient data available.</i> An ongoing Public Expenditure Review is expected to provide trends. In the meantime, IEG field visits and interviews revealed consistently high out of pocket expenditures and continued constraints to health services access by the poor. Any positive trend (if identified) could not be attributed to further scale-up of health insurance for the poor, since it is not fully implemented.</li> </ul>
<b>HSMP Outcome</b>	<i>Not achieved.</i> This law has not yet been implemented because (1) the costs of this provision (based on the definition of the package of services and their costs) have not yet been assessed; (2) concern that implementation is not affordable, given fiscal constraints; and (3) a new vision of health financing under the new Government oriented around universal health coverage financed by taxes vs. health insurance.
<b>Challenge #6: Introduce more predictable fiscal rules to finance health</b>	
<b>Government Prior Action</b>	This is addressed under the Law on Mandatory Insurance for Health Care, approved by the Council of Ministers on January 6, 2011, and passed by Parliament on February 24, 2011.
<b>Result Achieved</b>	Under this law, the Government has defined a rule for the systematic transfer of resources to the HII, maintaining the payroll contribution at its current level (3.4 percent, of which 50 percent financed by the employer, 50 percent by the employee) and using the cost of services as a criterion for financial transfers.
<b>DPL Outcome Measurement</b>	<ul style="list-style-type: none"> <li>Transfer of funds to HII in the National Budget maintained at same level as the previous year or increased: <i>Achieved</i>, as reported in the ICR. An ongoing PER should provide updates.</li> </ul>
<b>HSMP Outcome</b>	<i>Not yet, but likely to be achieved.</i> Cost of services not yet strictly used as the basis for financial transfers because the definition and costing of the package of services at the PHC and at the hospital level are still ongoing.
<b>Challenge #7: Improve the methods for contracting with providers and the capacity to monitor their</b>	

<i>performance.</i>	
<b>Government Prior Action</b>	The Government has (in 2009) unified the publicly funded purchasing of health services under one agency by transferring financing of hospitals to HII in 2009. Additionally, the HII signed performance contracts with 42 existing hospitals, January 2011.
<b>Result Achieved</b>	HII is officially assigned responsibility for the purchase of all health services (PHC and hospitals) since 2009, but its ability to fulfill this role has been constrained. Even though performance contracts were signed with 42 hospitals, 95 percent of hospital financing is still channeled through the Treasury, and paid on the basis of expenditure receipts, not performance.
<b>DPL Outcome Measurement</b>	<ul style="list-style-type: none"> <li>Percentage of payments to hospitals channeled through HII remained constant or increased in 2012. <b>Not yet achieved.</b> Only the payments to Durres Regional Hospital are channeled through HII. The other 41 hospitals have 95 percent of their budgets held in the Treasury and access them through submission of receipts. HII distributes the remaining 5 percent.</li> </ul>
<b>HSMP Support</b>	<b>Not Achieved.</b> Even though HII was officially assigned the responsibility for financing of hospitals in 2009 and performance contracts were signed with hospitals in 2011, HII only distributes 5 percent of the hospital budgets. Hospital budgets are prepared by Ministry of Health and approved by the Council of Ministers, based on historical budgets (number of beds) and not on the basis of services delivered and performance. Hospitals do not have a Bank account to receive budget funds. Rather, all the hospital financing goes to Treasury and hospitals must submit receipts against which they are reimbursed. While performance contracts have been signed, financing is largely not based on performance, except for the 5 percent distributed by HII. The only exception out of the 42 hospitals is the Durres Regional Hospital, whose payments are channeled through HII, due to its special status as a pilot hospital.

## **Annex I. Borrower Comments**

ALBANIA HEALTH INSURANCE INSTITUTE' COMMENTS ON THE DRAFT PROJECT PERFORMANCE ASSESSMENT REPORT (PPAR) FOR THE HSMP IN ALBANIA

### **COMMENTS FOR ANNEX 1 of the draft-report**

The IEG's report on Project Performance Assessment Report (PPAR) for the Health System Modernization Project, gives us a clear understanding of the development of this project through the years 2006-2012.

The HCIF of Albania agrees on the finding of this report. They give us a great insight of the system's development through years of the project and also tell us about the obstacles that have prevented the project to fully achieve its objectives, especially when it comes to the role of the HCIF. We are determined to continue our work in line with the new Government vision of continuing and deepening health financing and health system reforms, by polling all public resources under HCIF and using them effectively and by clearly defining the health care benefit which will be made for the whole population of Albania.

In the report, you mention that our system should move towards performance based or more advanced provider's payment system and we are determined to go this way. Drafting out, approving and having the backing of the Government for financing some of the most expensive and needed package of services for all our type of patients and groups of population, is our first step on the long road towards performance-based contract with the hospitals.

We agree with your finding of your report that there have been delays which have resulted in not developing a proper and needed Health Information System for the HCIF. We are determined to continue building our capacities towards an HCIF that will help our system to work properly and in need of health providers and our patients.

One of the reasons that you mention for not achieving the project's goals is the tensions between the MoH and HII at that time. Today there is a different political landscape and HCIF is working in full cooperation with the MoH and other partners in the health sector. This new reality gives us the confidence of working closely and succeeding in future cooperation with the WB for achieving our goals on the health sector.

After you publish the final report, we are willing to use all the finding and lessons learned from this report as a guideline for our future cooperation in playing our role on improving the health system and using the health financing resources in the best way possible.

**Yours sincerely,**  
**Astrit BECI**  
**Drejtor i Përgjithshëm**  
**Fondi i Sigurimeve të Detyrueshme të Kujdesit Shëndetësor**

ALBANIA MINISTRY OF HEALTH' COMMENTS ON THE DRAFT PROJECT  
PERFORMANCE ASSESSMENT REPORT (PPAR) FOR THE HSMP IN ALBANIA



REPUBLIKA E SHQIPËRISË  
MINISTRIA E SHËNDETËSISË

No/Prot 4320

Tirana, on 20.6 2014

To: Mrs. Tahseen Sayed  
Country Manager  
World Bank Office, Tirana  
"Ibrahim Rrugova" Street  
Vila No. 34, Tirana-Albania

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Re: Project Performance Assessment Report  
(Health System Modernization Project & Social Sector Reform Development Policy  
Loan)

Dear Mrs. SAYED

With respect to the draft report of above mentioned subject, I would like to express our thanks for sharing this important assessment for our review and comments.

The draft report, prepared by IEG, has done analysis for all component activities of the **Health System Modernization Project**, but unfortunately comparing with the ICR report, has not **evaluated correctly** the following achievements:

- improvement of the capacity of the Ministry of Health and HII to effectively formulate and implement health policies and reforms in provider payments, monitoring, and quality assurance;
- licensing and accreditation established by the MoH and the respective center is fully functional;
- improvement in the medical technology for all University and Regional Hospitals, both the access to, and quality of, primary health care services, with an emphasis on those in poor and under-served areas;

- Strengthened hospitals' capacity in diagnosis of breast cancer and treatment of hospital waste (through purchasing of autoclaves and mammogram equipment);
- improved governance and management in the hospital sector.

We would like to note that based on our administrative and survey data, the project has successfully achieved most of expected outcomes and outputs and we kindly ask the revision of the presented draft report by IEG.

For us, it is not acceptable the change of principal rating among ICR, ICR Review and PPAR. There are significant differences between ICR and PPAR evaluations.

The Ministry of Health of Albania shares different opinion with IEG, regarding the two project restructurings. According to IEG, these two actions "weakened the results chain, adding a number of investments not directly supporting the project objectives (hospital equipment) and deleting others that were critical to thjese objectives (quality grant facility, health information system software)".

We consider the investment in medical technology as vital ones, helping the Albanian patients for better diagnostics.

Regarding the software, it was considered a little bit premature and not fully covered by the funds of the credit.

In short run, I would like to confirm that all stages of the project, from design to final implementation has been done along with World Bank team.

We are pretty sure that our following highlights will help the revision of the principal ratings in the final Project Performance Assessment Report.

It is our pleasure to say that we appreciate the strong support and efforts the World Bank extends to the health sector in Albania.

We are convinced the World Bank will continue to be a reliable partner on a long-term base and will support the forthcoming reforms, through various projects and technical assistance support.

Please accept the assurances of my highest consideration.


  
**MINISTER OF HEALTH**
  
**ILIR BEQAJ**
  
