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PROJECT AGAINST CORRUPTION IN ALBANIA (PACA)

Technical Paper

RISK ASSESSMENT: CORRUPTION IN THE HEALTH SECTOR IN ALBANIA

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Abbreviations and Acronyms

AC	Administrative Council
ATC	Anatomical Therapeutic Chemical (drug classification system)
DC	Drug Commission on Drafting and Reviewing the Reimbursement List
EEHR	Enabling Equitable Health Reform Project (USAID)
EML	Essential Medicines List
EU	European Union
GDP	Gross Domestic Product
GOA	Government of Albania
GP	General Practitioner
HII	Health Insurance Institute
IPH	Institute of Public Health
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MTEF	Medium Term Expenditure Framework
NGO	Non-governmental Organization
NHA	National Health Accounts
PACA	Project Against Corruption in Albania
PHC	Primary Health Care
USAID	United States Agency for International Development
WHO	World Health Organization

INTRODUCTION

The Project Against Corruption in Albania (PACA) is a 2½ year project to assist the Government of Albania to fulfil its anti-corruption strategy and to improve integrity, transparency, and accountability in governance. This assessment is one of five risk assessments which PACA is conducting in specific sectors. The purpose of the health sector risk assessment is to assess the impact of health reforms on corruption, and specifically to:

- Summarize key elements of the current health financing system and health reforms;
- Describe the risks of corruption focusing on health financing and informal payments;
- Estimate the impact of health reforms on risks and prevalence of corruption in the health sector;
- Recommend measures to strengthen corruption prevention in the health sector.

The assessment is based on interviews with key informants and document review, and was finalised following comments from several experts, notably Rich Feeley, Associate Professor of International Health at Boston University School of Public Health. Assistance in the preparation and conduct of interviews was provided by Genci Mucollari, a local expert. A partial list of interviewees is provided in Annex 1. This report is organized as follows. Section 1 summarises the risks of corruption identified in the health system, and Section 2 summarises the recommendations of the report. Section 3 provides a background on health policy objectives and the health financing system in Albania, including the Government's anti-corruption plan for the Ministry of Health and progress towards its implementation in 2010. Section 4 presents and analyses the conditions within the Albanian healthcare system which create or increase risks of corruption. Section 5 presents the detailed recommendations of the report.

1 SUMMARY OF RISKS OF CORRUPTION

Risks related to four types of corruption in the Albanian health financing system are identified in four main areas: informal payments, hospital corruption, health insurance fraud, and conflict of interest.

1.1 Informal payments

The 2008-2009 Demographic and Health Survey (DHS) found that 56-62% of people who reported difficulties in accessing care attributed them to financial problems, with the poor disproportionately affected. Among Balkan countries, Albania has the highest mean share of informal payments. Poor households pay on average 8% of

total out-of-pocket spending on informal payments, compared to 4% for richer households (Bredenkamp, Mendola et al. 2010).

The Albanian government recognizes and has expressed concern about the problem of informal payments, which is important. It has also taken actions to try to reduce informal payments. For example, within the MOH's strategic priority "Improving the Health Financing System", two specific policy actions address informal payments: 1) creating a single pool of health resources and making payments formal, and 2) increasing wages for health workers to lower the incentives to accept informal payments (Ministry of Health 2010). MOH officials believe that the stricter policies implemented in 2010 have had an impact on reducing informal payments in hospitals, but this assessment suggests that more actions may be needed.

This study was unable to verify whether informal payments have actually decreased since the MOH reforms were implemented. However, the experience of other countries suggests that reforms such as those implemented in Albania - i.e. changes in patient referral procedures and payment modalities - are unlikely to eliminate informal payments on their own. More comprehensive reform efforts are needed. While the Government of Albania (GOA) has increased health spending as a proportion of total government expenditures in recent years, the changes in compensation for hospital-based physicians may not be enough to deter informal payments. In addition, quality of care is low, providing an incentive for patients to offer informal payments to assure higher quality. More analysis is needed based on empirical data to assess the extent to which health reforms are affecting informal payments among different income groups, and to identify pressures or incentives which still need to be addressed.

1.2 Hospital Corruption

The process by which hospital budgets are established is unclear and does not take into account the actual cost of providing quality care. The lack of transparency in budget management leaves the system vulnerable to funds being spent in ways that favour the priorities of individual service managers rather than health needs.

Interviews with providers and hospital managers reveal shortages of medicines and other key supplies. While the Ministry's anti-corruption strategy requires hospitals to post lists of drugs and supplies which should be available and to report on what is available, the impact of this management strategy for reducing corruption is unknown and needs to be evaluated.

Overall secondary income from user fees charged at the hospital level has decreased since 2009, as referral systems have tightened. The decline in secondary income probably reflects a decline in patient volume and overcrowding at hospitals, which is thought to be one driver of informal payments. At the same time, the decline in secondary income means a decline in bonus payments for staff (40% of secondary income can be used for bonuses). This may lead to a lower staff motivation, which is often associated with higher informal payments. The net effect of these reforms on

informal payment levels is therefore unknown and should be measured. Mother Theresa hospital – the country’s largest healthcare provider - has implemented stronger management procedures, including surveillance cameras, intended to control corruption in user fee collection.

1.3 Health Insurance Fund Corruption

Corruption risks in health insurance programs include fraudulent billing by providers, such as billing for false prescriptions, services never delivered, or patients who do not exist or were never seen. HII reports that the fund has taken several actions to control health insurance fraud, including conducting clinical audit procedures to detect over-prescribing and investigating providers based on prescription patterns.

HII has the ability to impose fines and terminate contracts of pharmacies and PHC providers. The agency reports that they use these anti-corruption tools. According to HII, audit procedures have helped reduce the frequency of fake prescriptions, so that over-prescribing is now the more pressing concern. Procedures are in place to allow providers and patients to lodge complaints at HII offices.

The government has made efforts to increase transparency of the drug reimbursement system by publishing price information to web sites and in books. However, the complexity of this system means that these efforts are probably not dispelling distrust or educating patients sufficiently. Additional transparency measures are needed.

1.4 Conflict of Interest

Corruption risks in the public pharmaceutical sector have been analyzed in detail in a separate study (Forzley, 2007). That study observed high vulnerability in the area of drug selection, mainly due to risks of conflict of interest and lack of control mechanisms. The government does not have an updated national essential medicines list (EML), and criteria for membership on drug commissions are lacking or unclear. These vulnerabilities could allow government officials with financial interests to bias decisions.

Some key informants suggested that human resource selection and promotion processes within the MOH and other government health institutions are politicized and that high level officials (including hospital service chiefs) may have conflicts of interest which are affecting their decisions. This may be an area for further analysis to identify financial interests which pose conflicts, and to assess whether they were properly managed. Such a review may indicate areas where current rules are insufficient, or where implementation of the rules is inadequate to prevent the abuse of power for private gain.

2 SUMMARY OF RECOMMENDATIONS

Section 5 presents further detail on the recommendations, timeframes, and who should be lead implementing partner.

Highest priority

- 1. Strengthen MOH stewardship (governance, leadership and direction) and monitor health reform progress**
- 2. Promote patient information and increase insurance enrolment**
- 3. Analyze household data on informal payments and knowledge of entitlements**

Next Priority

- 4. Strengthen hospital board governance and surveillance of cash collection**
- 5. Enhance transparency in drug selection, spending, and reimbursement**
- 6. Perform external audits and assure that actions are taken to address findings**
- 7. Continue investments in fraud control at HII**

3 BACKGROUND ON POLICY OBJECTIVES AND HEALTH FINANCING SYSTEM

3.1 Financing system goals

Financial protection and equity are the main goals of health financing systems. Individual health care spending should not push people into poverty, and relative to capacity to pay, the poor should not have to pay more than the rich (Kutzin and Furrer 2010). These principles of financial protection and solidarity have been adopted as goals in Albania.

The Government of Albania (GOA) Health System Strategy 2007-2013 affirms four strategic priorities of government:

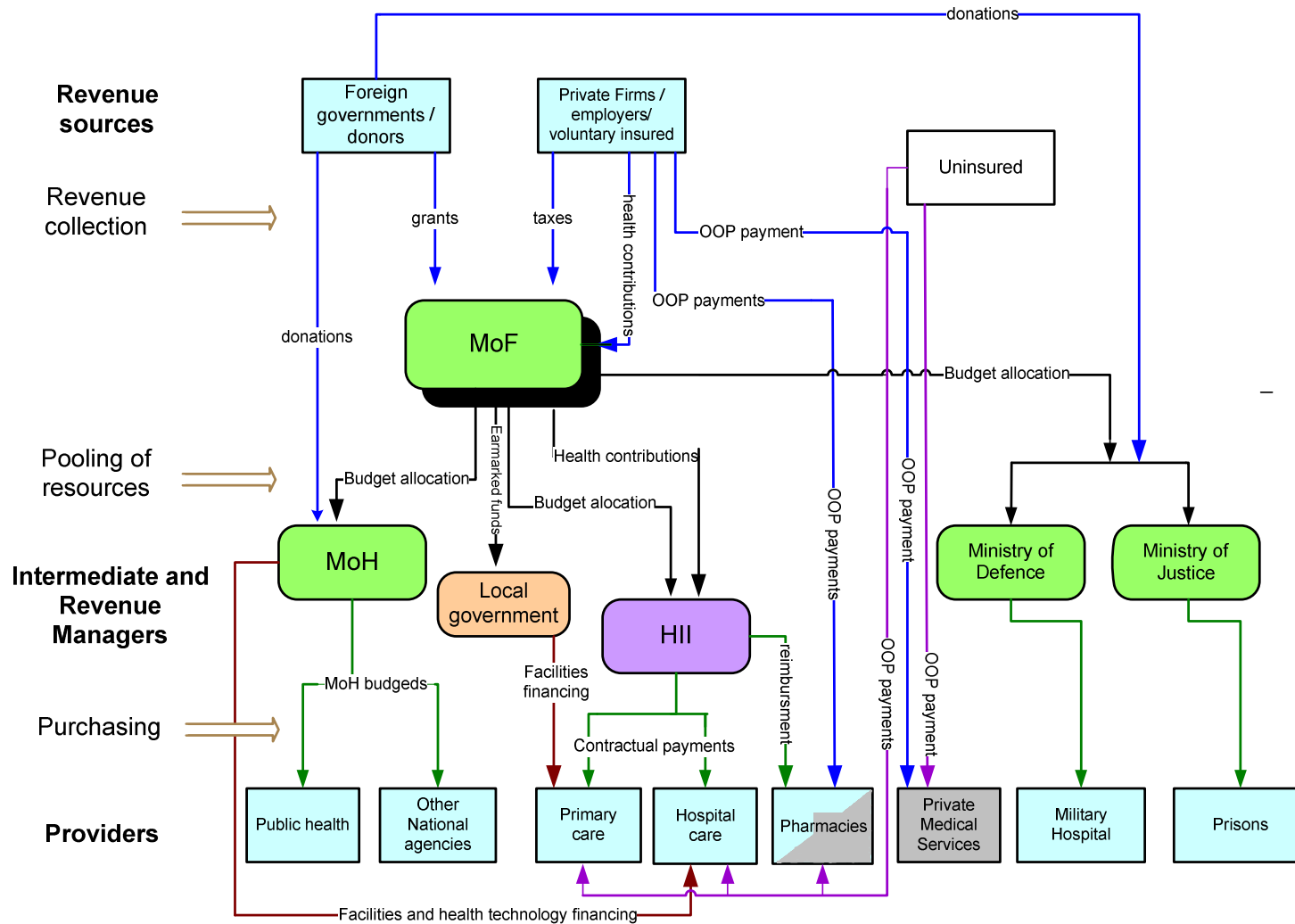
- increasing capacity to manage services and facilities efficiently,
- increasing access to effective health services,
- improving health financing, and
- improving health system governance.

Health financing policy objectives include increasing public resources for the health sector, improving compliance with payroll contributions, creating a single pool of

health resources, improving incentive systems for health workers to not accept or demand informal payments, and strengthening the role of the Health Insurance Institute (HII) as a strategic purchaser (Ministry of Health 2010). Specific policy objectives related to governance include reforming the MOH with emphasis on policy making, developing standards for health facilities, and ensuring regular production and dissemination of performance indicators.

The description of Albania's health financing system which follows is organized according to the WHO functional model of revenue collection, pooling, purchasing and benefits. To show how this model applies to Albania, Marku (2010) has elaborated the flowchart on the next page, illustrating the specific revenue sources, government agencies responsible for managing health resources, and different types of providers interacting in Albania's health care system.

Health financing flowchart



3.2 Revenue Sources and Collection

- Private, out-of-pocket spending is decreasing in Albania as a proportion of total health expenditures (47% in 2009). This includes formal and informal payments.
- A low but possibly increasing proportion of eligible population is contributing to the mandatory health insurance program. HII estimates that total enrolment, including contributing and non-contributing members, is 40.7% as of June 2011.
- Total secondary income from hospital user fees is decreasing, as referral systems have tightened. This policy is intended to increase insurance enrolment and reduce overcrowding at hospitals, thus reducing pressure for informal payments.
- Informal payments appear prevalent, though data quality is problematic. Studies suggest that 68-72% of patients paid for care that should have been provided free of charge, and 26-29% were “suggested to make” the payment (signifying it was not intended as a gift). (Institute of Statistics & Institute of Public Health [Albania] and ICF Macro 2010)

Revenue for health expenditures comes from both public and private sources. Public means of financing include general tax revenues and payroll taxes that are earmarked for the compulsory health insurance fund, while private contributions include out-of-pocket spending (i.e. the amounts that people pay as user fees or informal payments and not through taxes). It is generally considered good public policy for the public sector to finance a larger portion of health expenditures compared to private sources, both because health risks are unpredictable and unevenly distributed among populations, and because when serious illness does strike the expenditures required for treatment can be catastrophic and push a family into poverty.

Albania spent an estimated 5.65% of GDP on health in 2009 (see Table 1). Although spending as a proportion of GDP is low compared to Europe and the Balkans (NHA 2010), reliance on private contributions of revenue are declining and the share of public spending is increasing. For example, in 2009 out-of-pocket expenditures accounted for 47% of total health expenditures, compared to 60% in 2003 (World Bank 2006) and 56% in 2005 (Bredenkamp, Mendola et al. 2010).

Table 1: 2009 Health Expenditures by Source (in millions)

	Lek	Dollars	% total	% of GDP
Public financing	32,414	314	49.7%	2.81
Private financing	30,647	297	47.0%	2.66
Foreign aid	2,105	20	3.2%	0.18
Total	65,166	631	100.0%	5.65

Source: Albanian National Health Accounts (NHA), Final Report. July 27, 2010.
Tirana: Health System Modernization Project, p. 67.

According to official figures, the health sector accounted for 7.0% of total government budget expenditure in 2010, up from 6% in 2004 (Government of Albania 2010).

3.2.1 Health Insurance

According to HII officials, enrolment in the mandatory health insurance fund is low but increasing. According to data provided by the HII in August 2011 40.7% of the population, including contributing and non-contributing members, is currently enrolled, compared to 24.2% in 2009, a 70% increase.

Even if individuals have paid premiums or are entitled to coverage without contribution, many do not collect the insurance fund booklet which verifies coverage. According to informants interviewed for this assessment, this may be because some people still do not see the benefits of being insured, do not know the procedures for enrolment, or face other barriers in the enrolment process. Recent increases in enrolment may be partly due to a regulation implemented in 2010 which requires individuals who seek hospital outpatient care to either have a referral or pay a fee.¹ This new policy is intended to reduce overcrowding at hospitals by assuring that cases that can be treated at primary health care (PHC) facilities are seen there first and only referred when medically necessary. It is also intended to reduce pressure for informal payments. HII informants said that many people immediately sought insurance booklets when the referral fees were imposed.

For individuals employed in the formal sector, the insurance premium is 3.4% of salary, shared equally between the employer and the employed. The government contributes funds for individuals who are unemployed or exempt such as children, the disabled, etc.

¹ Order No. 52, dated 12.10.2009, "On the Implementation of the System of Referral to the Health System", and Instruction No. 558, dated 26.10.2009, "On the Registration, Identification and Movement of a Patient inside the Health Institutions, Pursuant to the System of Referral"

3.2.2 User Fees

Hospitals and PHC providers are allowed to charge formal fees to uninsured patients for outpatient visits and diagnostics, and to all patients for some services not covered by health insurance (e.g. expensive diagnostics). This is referred to as “secondary income”. Although hospital staff interviewed for this assessment believed that secondary income is increasing due to referral policy changes and tighter controls of fee collection, analysis of reported income revealed that secondary income has actually gone down, as shown in Table 2.

Table 2: Secondary Income from Hospitals and Health Centres (thousands of Lek)

	2009	2010	2011
All Hospitals	314,006	295,565	235,680
All Health Centres	56,294	77,785	76,851
Total Secondary Income	370,300	373,350	312,531
Percent Change over prev year		0.8%	-16.3%

Source: data from HII provided on 26 August 2011

3.3 Pooling

- Albania has made progress in pooling funding sources to reduce fragmentation, channelling increasing amounts through the Health Insurance Institute (HII). Investment budgets are still managed by the MOH.
- HII has been the sole source of government funding for PHC services since 2007, and has channelled funding to public hospitals since 2009. Though HII is a channel for hospital funding, it does not yet have the ability to negotiate global budgets with hospitals.

Prior to 2005, Albania’s health financing system was very fragmented, with funds being managed by the MOH, HII, and local governments. Fragmentation can be a constraint on the achievement of health policy objectives because it doesn’t allow for cross-subsidization and re-distribution of resources to protect against financial risk.

Albania has made progress in reducing fragmentation by creating a single purchaser system. The Ministry of Health has moved away from giving recurrent budget funds directly to providers, and instead channels subsidies to HII to buy services on the part of the population (Kutzin and Furrer 2010). In 2007, HII became the sole

purchaser for primary health care services² while in 2009 the government also began channelling funding for hospitals through HII. The move to pooled funding allows one single organization to take responsibility for setting incentives, promoting good performance, and assuring continuity of care. Investment budgets are still managed through the MOH.

² Decision of the Council of Ministers (No. 857), 20 December, 2006 on 'Financing of Primary Health Care Services.'

3.4 Purchasing and benefits

- HII appears to be financially solvent. Expenditures in 2010 were \$244 million, or about \$77 per capita, with 25% of the budget from contributions and 75% from the state.
- HII contracts with 1,000 pharmacies to provide prescription drugs to patients according to a complex payment scheme. Pharmaceutical reimbursement for the 991 covered drug items accounts for 23% of HII's total expenditures. Patient co-payments vary by drug item and type of patient, with some patients exempt.
- HII contracts with 500 health centres for services provided in 2,100 health centres and health posts. These facilities agree to offer a defined package of PHC services. 85% of the cost of the PHC package is paid in fixed monthly instalments, 10% is related to PHC providers' ability to reach utilization targets, and 5% is related to other performance indicators. PHC expenditures accounted for 23% of HII total expenditures.
- 39 hospitals receive payment through HII, although hospitals are not yet autonomous legal entities. Many hospitals do not offer a basic package of hospital services, yet HII is required by law to contract with them. Reforms are underway to cost hospital services in order to relate hospital payment to performance. Hospital expenditures account for 48 % of HII total expenditures.

Purchasing refers to how managers transfer revenues to health care providers. In 2009, HII contracted with about 500 Health Centres for services offered in 2,100 facilities (health centres and health posts). They also contracted with 1,000 private pharmacies (90% of all pharmacies in the country). HII also transferred funds to all 39 government hospitals (excluding mental hospitals). There are three private hospitals in the country but none contract with HII.

Health insurance fund expenditures in 2010 were \$244 million³, and total budget for HII in 2011 is estimated at \$266 million (see Table 2). About 25% of the budget comes from the required contributions paid by economically active enrolees or their employers, and 75% of the budget comes from the state.

Since 2006, HII has operated with a small surplus in most years. Currently their reserve fund is \$30 million (3 billion Lek, or about 13% of operating expenditures).

³ Using the 2008 population estimate of 3,170,048 (DHS 2010), this is approximately \$77 per capita.

Table 2: Health Insurance Institute Financial Data

	2010 Actual			2011 Budgeted		
	Lek ('000)	USD ('000)	%	Lek ('000)	USD ('000)	%
Income						
Contributions	6,433,798	62,343	24.9%	6,730,000	65,213	24.5%
State budget	19,402,109	188,005	75.1%	20,737,000	200,940	75.5%
Total	25,835,907	250,348	100.0%	27,467,000	266,153	100.0%
Expenditures						
Pharmaceuticals	5,927,030	57,432	23.5%	6,535,500	63,328	23.8%
Primary health care	5,898,770	57,159	23.3%	6,470,000	62,694	23.6%
Administration	573,039	5,553	2.3%	667,000	6,463	2.4%
Capital investments	48,068	466	0.2%	80,000	775	0.3%
Pilot Project in Durres	654,000	6,337	2.6%	669,500	6,487	2.4%
Hospital care	12,167,109	117,898	48.2%	13,045,000	126,405	47.5%
Total	25,268,016	244,845	100.0%	27,467,000	266,153	100.0%
Net income/% tot inc	567,891	5,503	2.2%	-	-	0.0%

Exchange rate: \$1USD =103.2 Lek (www.exchangerate.com, average for 2010)

HII uses its revenue to pay for benefits. These benefits include certain prescription drugs (for which the pharmacy can claim reimbursement), primary health care services, and hospital-based care. Benefit payment varies by type of provider, as described below.

3.4.1 Pharmaceuticals

HII covers the cost of some prescription drugs dispensed for outpatient visits accounting for \$57.4 million (23% of total) in 2010, compared to \$42 million in 2005.

The system for pharmaceutical reimbursement is complex. For insured patients, the pharmacy is partially or completely reimbursed for the price of the drug, and the patient pays the difference. Patient co-payments can range from 5% to 95%. The prices of drugs are regulated by government, with set margins allowed for wholesale distributors (12%) and retailers (29%). A 116-page price book is published each year with detailed information on retail prices, pharmacy reimbursements, patient co-payments, and other data for 991 drug items including different doses and formulations. The price book sorts alphabetically, by drug type, and is filtered in various ways (e.g. hospital drugs only).

The list of drugs identifies 409 low-cost “reference” drugs in each category. For other drug items in same category, approved as part of the benefit package but which have higher cost, HII pays only the reimbursement amount for the reference drug. Patients pay the balance. Table 3 shows sample price list information, with the first row of each pair of medicines the “reference” drug.

Table 3: Selected information from Albanian Drug Reimbursement List 2010

Bar Code	ATC Code	Generic Name	Form.	Brand Name	Distributor	Reference Price (Lek)	Co-pay (Lek)	Co-pay %	Insurance Reimb. (Lek)
2/105	A02BA02	Ranitidine 150 mg	f.c. tabl.	Ranitidine	PROFARMA	4	1.2	30%	2.8
2/52	A02BA02	Ranitidine 150 mg	tabl	Zantac	GLAXOSMITHKLINE	40	37.2	93%	2.8
28/2	A10BA02	Metformine 500 mg	f.c. tabl.	Diametil	AEGIS	3.4	0.2	6%	3.2
28/190	A10BA02	Metformine 500 mg	f.c. tabl.	Metformine	WHITE INT'L LTD	10.5	7.3	70%	3.2
53/105	B03BB01	Acid folic 5 mg	tabl	Acid Folic	PROFARMA	5.1	0.3	6%	4.8
53/1	B03BB01	Acid folic 5 mg	tabl	Filicine	ADELCO	6.4	1.6	25%	4.8
151/202	J01CA04	Amoxicilline 250 mg	caps.	Amoksicillin	RADOPHARMA	3.5	1.2	34%	2.3
152/6	J01CA04	Amoxicilline 250 mg	caps.	Almacin	ALKALOID	18.1	14.1	78%	4

Note: Percentage co-payment is calculated by author. Co-payment policies usually refer to percentages which are rounded. So, for example, Metformine index drug co-payment would be stated as 5% rather than 6%.

Adding further to this complexity, certain drugs are free of charge depending on the demographic status of the patient. Retirees, orphans, disabled persons, children, and other special cases can receive reference drugs without making co-payment, but must pay for the non-reference drugs, while disabled war veterans and some others are entitled to get any covered prescription drug without co-payment. These details are spelled out in the price list book, but the complex rules are a challenge for transparency and patient comprehension. The drug reimbursement list is updated once a year by the Drug Commission on Drafting and Reviewing the Reimbursement List (DC) appointed by MOH (Forzley 2007).

3.4.2 Primary Health Care

Health centres are autonomous public entities with their own bank accounts. HII contracts with them, as well as with private for-profit providers, for provision of a PHC package of services. Defined by the MOH, this package includes emergency care, preventive care, child health, adult care, women's health and reproductive services, elderly care, outpatient mental health services, and health promotion. Although in the future HII will have flexibility to establish selection criteria and choose whether to contract with a given provider, at this time all PHC providers are automatically entitled to contract with the HII. PHC expenditures were \$57.2 million in 2010, or 23% of total expenditures.

Given that medicines are reimbursed separately, the costs of the PHC package are considered more or less fixed. The cost per provider is established through historical cost analysis and includes salaries of staff, administration, and other service costs (emergency drugs, medical supplies, utilities, etc.).

Payments to PHC providers are split into three components. First, contracted PHC providers receive 85% of the total contracted annual payment in fixed monthly payments. This payment cannot really be considered as performance-based. The second payment component stipulates that providers can receive an additional 10% of the contracted payment if they achieve target utilization figures (called

“performance indicators”). Target figures are based on the standard/assumption that in urban areas each individual provider should be able to see 12 patients/day, while in rural areas providers should see 9 patients/day.⁴ In 2010, 83% of providers received the payment for achieving these performance indicators. Finally, the third component reserves 5% of contracted payment to be paid based on performance against quality indicators (called “bonus-based payments”). Indicators cover processes and outputs such as continuing education, follow-up for chronic care patients, and vaccination coverage). Last year 53% of providers received bonus-based payments.

In 2006-2007 HII recorded approximately 2.4 million GP visits per year, while in 2010 there were 5.4 million visits reported. HII officials attribute increases in PHC service uptake to their efforts to introduce performance indicators and payment incentives.

Similar to hospitals, PHC practices—particularly those in urban areas—gain secondary income from user fees. Regulations allow this revenue to be spent by the health centres with 40% allocated to investment costs, 30% to services, and 30% for staff incentives.

3.4.3 Hospitals

HII is required to contract with all hospitals, even though according to HII many hospitals do not currently offer a “basic package” of hospital services.⁵ For example, HII staff reported that they had examined data from 24 district hospitals and found that only 8 hospitals could offer the basic package, an additional 8 could offer 40-50% of the basic package, and 8 hospitals had insufficient staffing and infrastructure to offer anything but primary care. Another person interviewed cited a WHO study of maternity hospitals in Albania, using a well-structured methodology and adjusted for Albanian conditions, still found only one maternity in Tirana where quality of care was evaluated as very good. The rest were judged to be substandard quality.⁶ A law passed in 2009 makes hospital accreditation compulsory⁷, but progress in developing a fully functioning accreditation system is slow.

HII spent \$117.9 million on hospital care in 2010, or 48% of total expenditure. Although hospitals receive payment through HII, they are not autonomous entities. According to informants interviewed, the lines of accountability for hospitals are not clearly defined and HII does not determine the hospital budgets, which are a pass-through from the Ministry of Finance. Payments to hospitals are not split into components correlated to fixed costs, utilization or quality indicators, as with PHC providers. HII has started on a program to cost hospital services and intends to

⁴ Assuming a work-day of six hours and average visit time of 20 minutes, the urban standard is 66% of capacity, and the rural standard is 50%.

⁵ Although HII staff implied that the basic package was officially defined, one informant questioned this assumption and noted that this information is not known to all stakeholders.

⁶ Neither of the two cited studies could be independently reviewed during this assessment.

⁷ Law on Health Care (March 30, 2009), and the Law on Public Health (May, 2009)

complete this costing exercise by 2012 in order to create more realistic budget estimates which can be used in contracting, and to introduce performance incentives; however, the issue of hospital autonomy must still be resolved.

3.5 Recent health reform legislation

Two recent laws have bearing on governance in the health sector, including The Law on Public Health (2009) and the Law on Compulsory Health Care Insurance (2011). The Law on Public Health defines the principles of the public health system, the responsibilities of different public health institutions, and the activities and services to be provided. It defines the MOH as the lead institution in coordinating policy.

The Law on Compulsory Health Care Insurance, which will take effect in 2013, strengthens and clarifies the role of HII as a single payer. It defines the health insurance benefit package, contribution rates and methods, governing bodies and functions. As the law was passed at the same time this consultancy was taking place, an official English version was not yet available for review. Most people believe this legislation represents important progress on health reform, although the law took several years to pass and still requires enabling legislation before it can go into effect.

3.6 The Health Sector Anti-corruption Action Plan

As a component of the National Anti-corruption Action Plan, the Ministry of Health adopted a plan for fighting corruption in the health sector which includes actions to further the health financing reform objectives described earlier, and to increase transparency and accountability. Table 4 summarizes the objectives and activities in the plan.

Table 4: MOH 2010 Anti-Corruption Action Plan

Objectives	Measures / Activities
1. Improve transparency in price setting for medicines	<ul style="list-style-type: none"> • New regulations on structures and functioning of Commission on Medicine Prices • Publication of comparative data • Double stamp for control of medicines
2. Increase transparency and competition in public procurement and in planning of needs of health institutions	<ul style="list-style-type: none"> • Increase use of open procurement procedures • Publish procedures through e-procurement system • New rules on posting list of medicines and supplies available in hospitals and use of these supplies
3. Solve problem of informal payments and increase funding for “real cost” payment of services. Increase transparency in service delivery and improve health information systems	<ul style="list-style-type: none"> • New regulations for referral system, imposing fees for un-referred visits to hospitals • New regulations on financing hospital services from mandatory health insurance • Draft standard treatment guidelines and calculate service costs • Publish rights of patients • Create data warehouse system, automated hospital information systems, and unique health cards
4. Improve payment incentives for personnel	<ul style="list-style-type: none"> • Increase hospital autonomy

Source: Author’s summary of the MOH Anti-Corruption Plan 2010.

The Open Society Foundation Albania recently financed an external monitoring report on the 2010 anti-corruption plan in the health sector. Preliminary results suggest that some steps in the 2010 plan have been completed, especially passing of laws and regulations. However, progress on individual tasks does not mean that corruption risk will be reduced, since the steps themselves are interrelated. The report also raises questions about why the activities were chosen and how they are logically related to the desired results. Some important activities are only partially implemented; for example, the “double stamp” for assuring that only registered

medicines are reimbursed with public funds, and case-based payment based on treatment guidelines as a way to increase accountability in the use of hospital resources. A draft decision was sent to the Council of Ministers regarding the double stamp initiative and a company was selected to begin producing the stamps, but the program is not yet fully operational.

4 RISKS OF CORRUPTION

Abuse of public power for private gain is more likely to occur where health systems are weak, non-transparent, and where accountability is lacking. Corruption is also likely to occur where pressures to abuse are greater, such as with poorly paid staff or under-funded mandates for service. Risks related to four specific types of corruption in health financing systems like Albania's are discussed further in this section. For each, the current situation is briefly summarised and then the risk factors analyzed.

- Informal payments
- Hospital corruption (budgets, secondary revenue, drugs)
- Health insurance fraud
- Conflict of interest

Recommendations for strategies/policies to mitigate these risks are presented in Section 5.

4.1 Informal payments

4.1.1 Current situation

Among Balkan countries, Albania has the highest mean share of informal payments as a percentage of total out-of-pocket health expenditure, about 8% overall (Bredenkamp, Mendola et al. 2010). Informal payments have been an issue in Albania for some time (Albania Ministry of Health 2000) and were identified by the current Minister of Health as the main problem he faced when he took office.

According to the 2008-2009 Demographic and Health Survey (DHS), 68-72% of respondents reported paying for care that they should have been entitled to for free⁸, a rate not very different from that found nearly a decade ago (Bonilla-Chacin 2003). These payments are not all gifts, and may not be given willingly. Vian and Burak (2006), who specifically excluded gifts or "payments given willingly to express gratitude" found that 77% Albanians queried had made an informal payment other than a gift, and 67% thought they would need to make an informal payment the next time they sought care. In the DHS, 26-29% of respondents reported that they were asked to make an informal payment the last time they sought care. Previous studies have documented that informal payments are more prevalent in hospitals and for surgical procedures (Vian, Gryboski et al. 2006).

⁸ See pages 241-242 and Tables 13.14 and 13.15 in the DHS report (Institute of Statistics & Institute of Public Health [Albania] and ICF Macro, 2010).

Informal payments are part of a wider problem of financial access to care, a problem which affects the poor disproportionately. The 2008-2009 DHS found that 80-87% of adult men and women reported problems accessing health services: 56-62% of those with problems attributed them to lack of financial resources (income) to pay for services. In 2005, poor households reported spending about half the amount that the richest households spent on informal payments, but this expenditure represented twice the share of total expenditure (8% vs. 4%), suggesting that informal payments are a greater burden on the poor (Bredenkamp, Mendola et al. 2010).

The Albanian Government has acknowledged the problem of informal payments and is working to curb them. Within the MOH's strategic priority "Improving the Health Financing System", two specific policy actions address informal payments: 1) creating a single pool of health resources and making payments formal, and 2) improving the incentive system for health workers not to accept informal payments by increasing wages (Ministry of Health 2010).

The reforms address what MOH officials believe are some of the root causes: over-crowding and "patient mentality". In interviews, MOH officials stated that patients were making informal payments to be seen more quickly because of over-crowding in hospitals. An additional motivation is that patients think giving an informal payment will result in better quality, or they feel a social obligation to give.

Officials thought that the stricter referral policies implemented in 2010 and other reforms have "cut off" informal payments by reducing patient load in hospitals. Evidence claimed to support this assertion included a decline in complaints registered with the Minister of Health's office, and decreases in volume of outpatient visits at the hospital level. The Ministry did not provide specific data on the decline in complaints, and therefore this claim could not be verified. Declining secondary income at the hospital level, as shown in Figures 1 and 2 below, suggests that hospital outpatient visits have gone down, especially at Mother Theresa Hospital.

Figure 1

All Hospital Secondary Revenue Trend

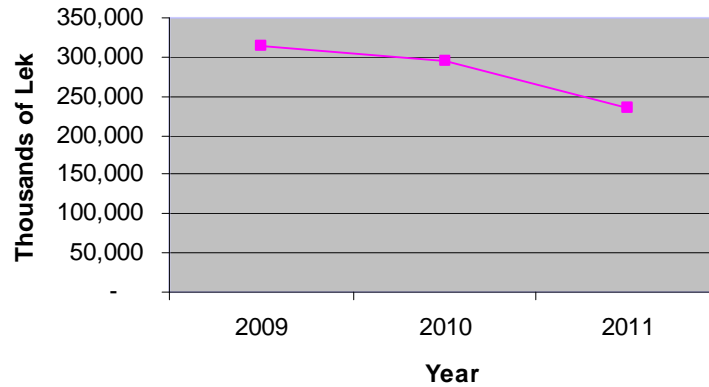
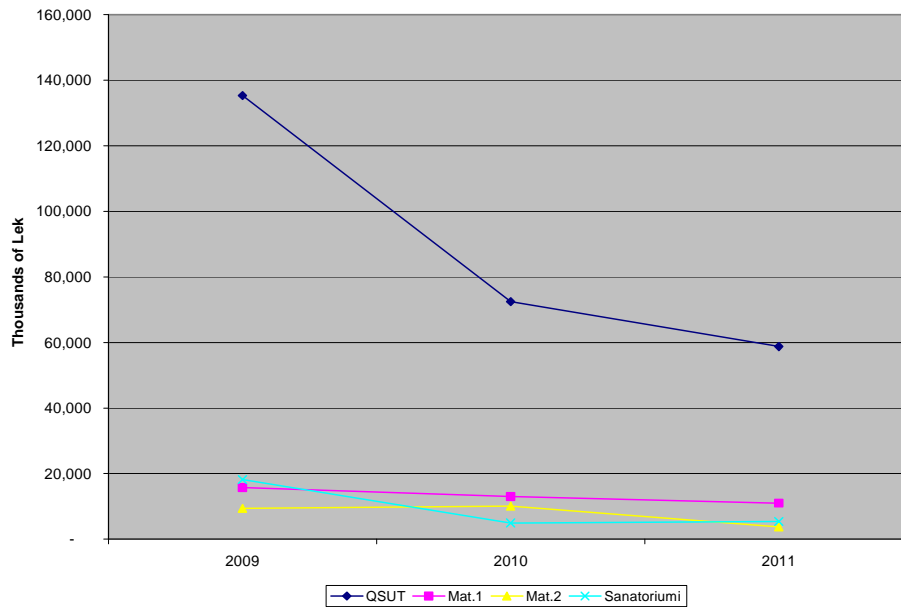


Figure 2

University Hospital Level Secondary Revenue, by Facility



Source of data from Figure 1 and 2: HII, e-mail communication from Naun SINANI to Taryn VIAN, 26 Aug 2011

Regarding the connection between secondary revenue and informal payments, the changes seen are not evidence that informal payments at hospitals are declining. While referral fees may have achieved the goal of reduced crowding at hospitals, there are **other reasons** people make informal payments besides jumping a queue. They might make informal payments to assure they get a certain doctor or better quality care, or because they are forced to pay in order to be treated at all.

The other logic for the reform was that increased hospital-level secondary income would mean **more motivated clinical staff**, as the additional funds were shared with doctors (40% of secondary income can be used for staff bonuses). Unfortunately, with the income in decline it means doctors may be receiving less. The reduction in secondary income may actually increase pressure for informal payments.

Most MOH officials interviewed for this study stated that providers do not ask for or accept informal payments any more, and that informal payments which continue are either gifts, or are forced on providers by patients who feel obliged by social custom to offer something to a clinician who has treated them. A remaining task, according to MOH officials, is to implement strategies to change attitudes and mentality so that patients understand that they do not need to make informal payments and are damaging the system by doing so.

During interviews with other informants, however, there were doubts about the extent to which informal payments have been reduced by the policy reforms to date. Stories such as those in Box 1 suggest that informal payments continue, and that providers may still be requesting them directly. The events and opinions expressed are within the last 4 months, e.g. well after the reforms which MOH officials believe have “cut off” informal payments.

Box 1: The continuation of informal payments at hospitals

I went to the government hospital to see a specialist who is a friend of mine. I did not have to pay. He said that I needed an x-ray. "It is your choice," he said. "You can have the test here, or you can come to my [private] clinic." I decided to have the test downstairs in the x-ray department. I didn't offer to pay because I wanted to see what they would say. Finally they told me that I had to pay 500 lek. When I gave the money, they put it on a shelf under the desk. I saw that the amount I paid was less than half of the price listed. *(male patient, recounting experience in December 2010)*

A cleaner in our building, she makes very little money. Her daughter was having problems with her pregnancy. I called a friend of mine who is a private doctor. I wanted to know if she knew someone in the public hospital who would see the daughter without asking to be paid. The friend told me she was sorry, but no one would attend to the daughter without being paid. *(Albanian doctor, recounting experience in March 2011)*

I need to survive and raise my children. Taking into account how much income I need to live, if I don't get what I need, then someone else is profiting from this. *(Albanian doctor who works in public and private practice, explaining why he accepts informal payment)*

Providers participating in a focus group in Tirana, organized by a civil society organization earlier in 2011, also admitted that the practice of informal payments continues. They stated that low pay was the main reason. Other reasons stated included patients not being insured due to low awareness of the advantages of insurance.⁹

4.1.2 Analysis

Informal payments affect financial protection, equity, and transparency (Gaal, Jakab et al. 2010). The experience of other countries suggests that narrow reforms such as those implemented to date in Albania, i.e. changes in patient referral procedures and payment modalities, are unlikely to eliminate the practice of informal payments on their own. Informal payments are more than simply a tradition of giving thanks or a patient mentality: they also reflect the underfunding of salaries and medicines and lack of accountability for delivering quality services. Comprehensive reform efforts are needed.

⁹ Raising Awareness and Rights and Obligations of Patients and Medical Staff at Hospital Level as an Important Step in the Fight Against Corruption, grant funded by the Albanian Agency for Support of Civil Society.

In Kyrgyzstan, a comprehensive reform policy included three components:

- Higher levels of pooled funding for health services, meaning that the resources increased overall and that the system channelled those resources through only one payer responsible for contracting with providers;
- New provider payment methods based on capitation for outpatient care and case-based payment for inpatient care. Capitation payment means that providers are provided a set amount per year for each person enrolled in their practice, regardless of how much they use or do not use health care services, while case-based payment involves a payment per diagnosis-related group (such as heart failure, or caesarean section delivery). Both methods of payment involve a high level of cost analysis to determine payment rates in advance;
- Regulation of a transparent, realistic set of defined benefit entitlements and co-payments. The key point here is to specify a package of services that the government can afford to provide, so that the entitlements can really be funded and delivered. Clear co-payment policy with reasonable official rates reduces opportunities for providers to extort or patients to offer informal payments. (Gaal, Jakab et al. 2010).

The country downsized physical capacity in the hospital sector and used the savings to increase funding for salaries and medicines. After 10 years, the system has proven successful in reducing reported amounts paid informally by households, though not in eliminating these payments.

As described in Section 2, the GOA is implementing a set of health reforms designed to transform institutions and strengthen health systems in ways which are likely to reduce informal payments *over time, if fully implemented*. Similar to Kyrgyzstan, the GOA is moving toward pooled funding, developing similar provider payment mechanisms, and has defined entitlements and co-payments. But the system is not fully implemented. While the GOA has increased health spending as a proportion of total government expenditures in the past years and increased doctors' salaries, it is not clear that the changes in compensation for hospital-based physicians have been enough to deter informal payments.

4.2 Hospital corruption: budgets, secondary revenue, medicines

4.2.1 Current situation

HII “contracts” with hospitals on paper, but in practice the MOH is responsible for appointing the hospital director, so lines of accountability are unclear. The insurance fund does not set hospital global budgets, and cannot selectively contract (i.e. choose not to contract with a hospital which doesn't meet standards). It does not set targets for hospital utilization, quality, or efficiency. Funds are not fully pooled: HII

provides the hospitals with funding for recurrent expenditures (salaries, medicines, supplies), while the MOH covers investment costs (even including minor equipment and furniture like chairs or minor renovation).

The process by which hospital line item recurrent budgets and investment budgets are established is unclear, involves little participation, and does not take into account the actual cost of providing quality care. This lack of transparency, participation, and information in budget management leaves the system vulnerable to funds being spent in ways that favour the priorities of individual service chiefs rather than health needs and service objectives. According to some informants, chiefs of services in some hospitals are very powerful and “cannot be touched”. They are said to have “created monopolies” in how they operate, not allowing younger staff or new personnel to gain opportunities unless they go along with the decisions and priorities of the chief. This suggests that hospitals may be run through patronage systems which do not encourage the best quality care and rational use of resources. Whether or not these specific allegations are true, the current budgeting system does little to prevent risks of patronage.

Interviews with providers and hospital managers also reveal shortages of medicines and other key supplies. Different explanations for drug shortages were given. By one account, the shortages are due to procurement regulations which do not allow large enough quantities to be procured so that hospitals have enough drugs in the pipeline to make it through the order cycle. A second explanation was that hospital funds are being absorbed by expensive chemotherapy drugs, suggesting problems with internal processes of resource allocation. A third explanation was that doctors and nurses remove supplies and medicines from stock rooms as soon as they are purchased, keeping them in separate, personal stores so that certain providers will have access to supplies needed to perform procedures. Some people suspected this was done to earn informal payments and is encouraged by powerful service chiefs, for themselves and favoured associates.

A recent Ministerial order requires hospitals to post lists of drugs and supplies which should be available, and to report on what is available. We were not able to verify that these lists are posted or to discern any effects. Some informants were sceptical about the effect of this policy on actual availability of drugs.

Mother Theresa Hospital (by far the country’s largest healthcare facility) has implemented hospital management procedures intended to control some risks of corruption in fee collection. Surveillance cameras have been installed in some areas and patient flow controlled, to make sure that monetary transactions take place only in publicly visible places. According to one key informant, daily revenue collection is higher than before, although as shown in Figure 2 this is not born out by the data. It is curious that the use of surveillance cameras did not increase revenue. If staff had previously been skimming (embezzling) revenue, it would normally be expected that cameras would increase the chance of detection, thereby making it less worthwhile to attempt to skim. It could be that the policy change discussed earlier had such a strong negative impact on secondary income (through a reduction in outpatient visits

and ancillary service use) that it offset the positive impact that surveillance might have had in increasing revenue. Alternatively, it could be that secondary income is being systematically under-reported.

4.2.2 Analysis

Health reforms such as the single payer system, hospital autonomy to contract with HII to provide care, and case-based payment systems are intended to provide incentives for better performance and increase accountability. These reforms have achieved some success in other countries, and if properly implemented there is reason to believe they could be successful in Albania.

But the reforms have not been fully implemented, and timetables which claim they will be implemented in a year seem overly optimistic. In the meantime, vulnerabilities to corruption exist because the current line item budgets are unrelated to objectives or actual utilization, and budget management is not transparent.

The different explanations for the drug shortages imply different solutions. If the shortages are due to procurement regulations which do not allow large enough quantities to be procured so that hospitals have enough drugs in the pipeline to make it through the order cycle, this suggests that changes in procurement regulations could reduce shortages. If shortages are due to internal decisions regarding allocation of funds to particular drugs, or personal interference from staff, this suggests the need for stronger drug management systems with tighter internal and external monitoring and performance indicators. Further analysis is needed to determine the true causes of drug shortages and the necessary interventions.

Embezzlement is a major risk in official user fee systems. For example, clerks may charge official fees to patients but record receipt of lower sums (pocketing the rest). They may exempt friends and family from paying fees, or charge fees that are lower than required in exchange for a kickback. Higher level staff could be receiving pay-offs to accept falsified records. The hierarchical controls being implemented in Mother Theresa hospital are appropriate for these types of problems.

Hospitals also face a second challenge: how to assure that decisions on spending secondary revenue are transparent and limit opportunities for self-dealing or rewarding of “insiders”. Hierarchical controls (internal to the system) are not as effective in controlling spending decisions. Procedures which allow external oversight, wider participation in spending decisions, and better reporting on how secondary revenue was used in relation to hospital goals, are better methods to promote accountability.

4.3 Health Insurance Fraud

4.3.1 Current situation

A major type of corruption in health insurance programs is **fraudulent billing** by providers, including billing for false prescriptions, services never delivered, or patients who don't exist. HII reports that the fund has taken several actions to control health insurance fraud. First, the agency staffs an **Auditing Directorate** at

headquarters and each of the 12 regional offices has an auditing section. These offices are responsible for monitoring contracts to assure that services are actually provided.

Secondly, HII has invested in **information technology**, including systems to control financial transfers, document communication between HII and providers in writing, tally or add up the monthly visits made to the various individual care providers and outreach posts affiliated with health centers (a measure which triggers provider payments), and collect data on filled prescriptions from pharmacies. They also plan to use computer models to calculate case-based payments for hospitals. The use of computer technology allows verification procedures to be applied and speeds up decision making and analysis.

HII is computerizing the enrolment records by health centre to help detect **over-estimated enrolment**. PHC providers are supposed to enrol people from their catchment area, but according to some, they avoid this step by gathering lists from other administrative sources. While budgets are now mainly determined by historical spending, inflated enrolment records may be a strategy to drive up budgets in the future.

HII reviews prescription data to detect anomalies which might indicate **false prescribing**, i.e. a prescription which is submitted for reimbursement but which was not written by a legitimate doctor, or does not have patient data to back up the need for the prescription. If pattern analysis indicates a possible problem, auditors will go to see the doctor and examine patient records. They might even go see the patient to determine whether the patient really saw a doctor or was prescribed and picked up a prescription.

The MOH is implementing a "double stamp" procedure which will also help control prescription reimbursement fraud. Legitimately registered locally produced and imported drugs will have a double stamp affixed to the package. When the unit is sold by the pharmacist, one of the stamps is removed and affixed to the reimbursement request. A company has been chosen to begin implementation of this system. When fully operational, this system could deter pharmacists from charging for expensive Drug A and dispensing cheap Drug B, charging HII twice for the same drugs, or charging HII for drugs not dispensed at all. The double stamp does not control for overcharging of the patient, kickbacks, or bribing doctors to influence prescription patterns.

Physicians who own pharmacies, or who have made arrangements with drug companies or pharmacies to receive kickbacks based on prescribing, may have incentive to **over-prescribe** drugs. Clinical auditing strategies are used to assess over-prescribing, i.e. comparing diagnosis with standard treatment guidelines, but this is a more difficult type of fraud to detect.

If it is found that a pharmacist has engaged in fraud, HII can **impose fines** or terminate the contract. If a physician is found to have engaged in prescription fraud or to have directed people to certain pharmacies based on relationships, HII can fine

the health centre and recommend that the staff member be dismissed. HII has imposed fines and made these recommendations in the past. According to HII staff, the audit procedures used have reduced the frequency of fake prescriptions, so that over-prescribing is now the more pressing concern. HII also has **complaint mechanisms**. Providers and patients can lodge complaints at any HII office in regions or districts. These complaints are reviewed and can trigger audit.

Another type of fraud in health insurance systems is when patients pass their insurance card to an uninsured friend or relative. Albania's anti-corruption plan for the health sector includes an initiative to issue photo ID cards which are a good deterrent strategy, though progress on this reform has been delayed because of efforts to integrate the health insurance card with a national ID card reform. According to some informants, it seems unlikely that patient fraud is currently a large problem.

The main **governance body** for HII is the Administrative Council (AC). The AC is composed of nine members including the Minister of Health, Minister of Finance, Minister of Social Affairs, Director of the Social Insurance Institute, and people representing trade unions, health care providers, and private employers, self-employed individuals, and consumers. The AC elects and evaluates the performance of the General Director of HII, approves the design of benefits packages, sets financial and other personnel/administrative procedures, and has budgetary authority.

4.3.2 Analysis

The **complexity of the drug reimbursement list** makes it difficult for consumers to understand their entitlements. With 991 drug items which can be reimbursed and variable co-payment percentages, it is understandable that patients are confused and therefore distrustful. The pricing book is an effort toward transparency, but it is too complicated for the average patient. In addition, patients may not have easy access to the price book.

One way to simplify the drug reimbursement system is to create a limited set of co-payment levels or classes, i.e. 2 classes of co-payment amount (low and high) for each reference drug and 2 classes for each non-reference drug. Each drug would then be labelled as Class A, B, C, or D. Patients could refer to a table to find their fixed co-payment amount for the class of drug prescribed. It may be worthwhile to study this type of option further.

The **audit mechanisms** which HII has put in place, including targeted investigation of providers based on practice patterns and complaints, are well suited to control the types of fraud they have identified as potential problems. An additional aspect of fraud control which HII might consider is to provide "Explanation of Benefits" (EOB) documents to patients, at least on a selective basis when providers' billing behaviour is questionable. The notice would explain to patients the services which were reimbursed, and who received the reimbursement. If the patient did not actually

receive the billed services, s/he would be asked to call a number and report the problem.

It is an axiom of fraud control that fraudsters are always changing their game in response to control mechanisms. While HII's investigations are now triggered by analysis of certain thresholds and prescription patterns, if fraudsters learn of these procedures they may change their pattern of abuse to run "below the radar". HII will need to keep ahead of the game by changing their control thresholds and triggers, and by allowing staff and other stakeholders to identify and raise new fraud problems for attention and analysis. HII should also use focus groups of patients and providers to determine areas of systems vulnerability and suspicious behaviour which may be worth monitoring.

New payment systems and changes in HII policy also create additional risks for fraud. Investigation methods will need to be adapted for capitation-based PHC payments and case-based hospital payment systems. For the former, audit of enrolment records will be important, while for the latter, HII may need to audit for ghost patients or falsified reporting of inputs used in treatment. Another risk of case-based hospital payment systems is "upcoding", a fraudulent practice where hospitals assign medical codes to patient cases in a way designed to command more money from HII reimbursement. HII will need to create rules to detect and penalize hospitals for inappropriate upcoding.

4.4 Conflict of Interest

4.4.1 Current Situation

Corruption risks in the public pharmaceutical sector have been analyzed in detail in a separate study (Forzley, 2007). That study observed high vulnerability in drug selection due to risks of conflict of interest. The government does not have a national essential medicines list (EML), which normally is used as a guiding framework for public sector registration, selection, reimbursement, and procurement. Some selection functions are carried out by the Drug Commission on Drafting and Reviewing the Reimbursement List (DC), but criteria for membership on the commission are lacking. This could allow government officials with financial interests in supply companies to bias decisions.

4.4.2 Analysis

While Albania has made some progress in reducing vulnerability in procurement through the introduction of e-procurement procedures, there is little evidence that this has reduced conflicts of interest. Without transparent selection of bidders, Albania is vulnerable to corruption in the form of illegal payoffs or other types of pressure exerted by suppliers. The lack of transparent criteria and processes for reimbursement decisions also creates vulnerability to insurance fraud. The GOA or relevant institutions (for example the High Inspectorate for the Declaration and Audit of Assets, to the extent that Commission members are subject to the Albanian

conflict of interest and asset declaration laws) may need to conduct specific analyses of high level officials and committee members to determine whether financial conflicts exist, and to assess the appropriateness of procedures currently used for managing these conflicts (e.g. disclosure or recusal).

5 RECOMMENDATIONS

This section summarizes risk reduction strategies. Within each recommendation, the implementation period, end result, lead agency or implementation partner, and major steps are described.

5.1 High Priority

1. Reinforce MOH stewardship and monitoring of reform progress toward one payer system delivering quality health care services

A fully implemented **one payer health care system**, where HII is able to contract selectively with providers to pay them adequately for delivering **high quality care**, increases accountability. Reforms such as the new health insurance law, patient-level information systems and costing systems, and monitoring and evaluation (M&E) tools and processes, are needed to achieve this goal. Reforms which increase the quality of health care are actually anti-corruption measures because they reduce the need to ensure quality through unofficial means like bribes and informal payments.

The MOH must be an effective steward in assuring these reforms move forward and in implementing specific anti-corruption actions. **Reform implementation progress needs to be monitored closely** using the recently developed Ministry of Health Monitoring and Evaluation Plan (Ministry of Health 2010) and active participation of external watchdogs like the media and NGOs. In addition, the MOH needs to be more involved in **managing the agency's anti-corruption activities**. Currently the MOH anti-corruption plan exists but is not well known among MOH staff and may be perceived as a requirement imposed from the Prime Minister's office, rather than a tool for stewardship.

Government actions:

- The MOH should continue to strengthen its M&E unit so that it can regularly produce and disseminate timely reports.
- The MOH should draft and disseminate a step-by-step plan on the annual process of developing and implementing an anti-corruption plan of action in collaboration with civil society organizations and human rights groups.
- The MOH should consider establishing a specific Task Force or working group whose mandate it is to draft strategies to curb corruption. This group would report to the Minister of Health about the progress and achievements. Members of the group might include MOH satellite institutions and other

health entities, EU, UN agencies and other donors, and civil society organizations.

- The MOH should collaborate with donors to provide more specific training on how to prevent and fight corruption targeted to staff at service delivery points, managers and officials at the MOH, students at the Faculty of Medicine and the Faculty of Social Sciences, and staff of NGOs.
- The Centre for Continuing Education and other training programs in the health sector should include anti-corruption topics in their existing curriculum.
- The GOA Agency for Support of Civil Society should provide grants to Albanian non-governmental organizations (NGOs) to undertake monitoring of health reform progress and transparency of policy implementation in health sector.

Timeframe: Begin immediately. The Monitoring and Evaluation unit is already producing reports with at least some of the planned indicators, although reporting on all indicators may take 1-2 years. Design and dissemination of anti-corruption planning and implementation process should take 3 months. Task force should be constituted in 3 months. Planning for new anti-corruption training and integration of anti-corruption topics into existing training programs should take 6 months. Agency for Support of Civil Society should adopt criteria to promote health transparency activities for the next grant cycle (i.e. September).

Donor actions:

- EU, UN agencies and other donors should be approached to support comprehensive programs against corruption with specific objectives by involving civil society organizations, interest groups, and other stakeholders.
- Donors should support Albanian journalists to expand dialogue, through the media, on health reform progress and policy choices, and to increase quality coverage of corruption issues including different stakeholder views on the causes and consequences of informal payments.

Timeframe: Within 3 months, a donor coordination meeting should review these recommendations and decide on support activities to be implemented.

2. *Promote patient information and increase insurance enrolment*

Patients and the general public can help to prevent corruption if they are educated about their **entitlements** and know where and **how to lodge complaints**. A particular area where patients lack knowledge and could benefit from clearer information is **drug benefits**. Analysis of drug reimbursement patterns can help

determine the top drugs prescribed for common illnesses, and fact sheets for patients can help convey simplified price and co-payment information.

Patients who understand their entitlements and fee schedules may be more willing to sign up for insurance, which is desirable because expanding coverage can help reduce pressure for informal payments. Other ways to encourage enrolment should also be explored, including training hospital administrative staff to **enrol patients in the insurance program at the same time they are seeking care.**

Government actions:

- HII should survey public knowledge of insurance benefits, drug prices, and governance processes (such as complaint mechanisms or health centre governance meetings which are open to public).
- HII should analyze past prescription patterns to determine the most frequently prescribed drugs for a sub-set of common illnesses, then develop fact sheets to provide drug pricing information and co-payments required for these commonly used drugs. Fact sheets should be provided to all enrolled members, posted on web site, and posted on information boards in waiting rooms in hospitals, health centres, pharmacies, and other community centres
- Hospitals should coordinate with HII to enrol patients in insurance at the same time they are seeking care, in a streamlined administrative process.

Timeframe: HII should complete survey of knowledge and develop fact sheets, and hospitals should be enrolling patients, within 1 year.

Donor actions:

- Donors should fund studies by HII and civil society organizations to evaluate patient knowledge of pricing rules and insurance entitlements after interventions such as the drug fact sheets, etc. The results of these studies should be discussed with stakeholders such as MOH, HII, and journalists, and can be used to inform planning for additional activities to improve public knowledge and insurance enrolment.

Timeframe: Donors should coordinate and select lead donor for this activity within 6 months. Survey should be completed within 18 months (after implementation of fact sheets and hospital-based insurance enrolment).

3. Collect household-level data on informal payments to monitor reform progress

Empirical data are needed to verify the frequency and amounts of informal payments being paid, especially for hospital care as this is where informal payments are reportedly the highest. A household survey could help achieve this goal. Interviewed post-discharge at home, it is possible to obtain more accurate responses about actual

informal payments given, and to probe for whether patients were directly asked to pay, felt unspoken pressure to pay, or were making payments voluntarily. Collecting data on discharged patients also allows rates and levels of informal payment to be compared by socio-economic status to assess financial access for poor versus non-poor households.

Donor Actions:

- Donors, in collaboration with MOH and HII, should fund a household survey of discharged patients to determine levels and amounts of informal payments and how they affect households of different income levels. This is essential to evaluate whether informal payments have been curbed.

Government Actions:

- MOH and HII should collaborate with donors in development of survey instruments, implementation of study and analysis of data.

Timeframe: First survey within next 6 months; additional survey after 2 years of implementation.

5.2 Next Priority

4. Strengthen hospital board governance and surveillance of cash collection

As reforms toward hospital autonomy are implemented, it is important to think about governance structures. Right now, hospital governance boards are comprised of service chiefs and function more as a management committee. To provide a check on discretion of management, the hospital board should have representation from beneficiaries and funding organizations as well as management. Hospital boards have been shown to increase accountability and reduce informal payments in Bolivia and Kenya (Di Tella and Savedoff 2001; Vian 2006).

User fees at the hospital level are an important source of cash revenue. Secondary revenue is less important at PHC facilities, although data show that secondary income increased 38% in 2010 compared to 2009.¹⁰ Cameras which have been put in place to monitor revenue collection areas of Mother Theresa Hospital are a good corruption deterrent. This strategy should be evaluated and possibly expanded to other hospitals and large health centers. However, administrators should be aware that if people see no impact from the surveillance systems - that is, no one is punished - the practice of stealing user fees may increase. Additional measures for detecting fee diversion should be considered if appropriate and cost-effective. These might include placing under-cover employees in fee collection positions to observe and report on the actions of others, and sending "mystery patients" through the system to report on their experience from the client viewpoint.

¹⁰ 77.7 million Lek in 2010, compared to 56.3 million Lek in 2009. Source: HII, 26 Aug 2011

Data systems should be put in place to measure fee revenue and compare to expected revenue based on volume of services delivered. This is best done by limiting the fee collection points and installing electronic point of purchase cash registers (as already exist in some private healthcare institutions). These machines can provide itemized bills to patients while also facilitating summary reporting at the end of the day. Such reports can help detect discrepancies between expected and actual revenue, allowing managers to trouble shoot. A similar system implemented in a regional hospital in Kenya increased user fee revenue by 400% and reduced patient complaints about corruption in user fees (Vian 2006).

Government Actions:

- Hospitals should expand membership on hospital boards to include staff (other than service chiefs) and participation of other stakeholders such as patients associations, consumer groups, civil society organizations and other local institutions. In addition the role of local government in hospital boards should be increased and strengthened.
- HII should encourage stronger participation and regular attendance by local government representatives on PHC boards.
- The MOH and HII should support training of hospital boards in good governance.

Hospital Actions:

- Hospital Board members should develop transparent processes for reporting on uses of secondary revenue (e.g. decision making on bonus payments, capital investments, etc.).
- Hospital Boards should begin to play a role in oversight of budget formulation and spending (i.e. review budget assumptions, approve draft budget before it is sent to MOH or HII, review annual budget versus actual performance reports, request rationale and plan for drug procurements and reports on stockouts).
- Hospitals should ensure that revenue collection points are adequately staffed, expand current surveillance of revenue collection, and discipline employees caught stealing user fee revenue.
- Hospitals should implement electronic cash registers to automate patient and insurance billing, cash collection, and cash reporting.

Donor Activities:

- Donors should provide technical support for implementation of the above mentioned activities
- Donors should fund evaluation of the impact of electronic cash registers and hospital surveillance activities in 1-2 hospitals, to determine effectiveness and return on investment before activities are rolled out to all hospitals.

Time frame: Actions should be initiated within 1 year. Governance strengthening should take 3 months. Implementation of cash registers and impact evaluation may take 6 months.

5. Enhance transparency in drug selection, spending, stock movements and reimbursement

MOH and HII analysts are currently developing standard treatment guidelines for PHC providers and hospitals. These standard treatment guidelines should be the basis for best practice in the use of drugs, and can inform the design of an updated national Essential Medicines List. Criteria for membership on the EML and DC, and procedures and criteria for adding or deleting drugs from either list, should be established and publicized. Albanian civil society groups or pharmaceutical policy researchers should be enlisted to provide external review of the drug lists for under-inclusion (where effective, inexpensive drugs are omitted in favour of expensive brand-name drugs) and over-inclusion (where many “me too” drugs in the same therapeutic category are included), as these may indicate capture or undue influence by industry.

The MOH requires that reports of consumables purchased by hospitals be made public, in an effort to increase availability of drugs. Stakeholders we spoke with during this study are not aware or convinced that drugs are becoming more available. Rather than making new recommendations in this area, the MOH should consider the indicators already included in the MOH M&E Plan related to drug availability, and make sure those indicators are measured and made available to stakeholders.

Timeframe: Stock-out indicator measurement is already in MOH M&E work plan. Public release of data should take place within 12 months. Linking hospital payments to drug availability may depend on implementation of the health insurance law over next two years. A more firm timeframe should be developed in collaboration with MOH and HII. Other actions (updating of EML, review of drug commissions for financial conflicts of interest, donor-funded reviews) can begin immediately.

Government Actions:

- MOH should measure drug stock-out indicators at the individual hospital level and release data to the public (part of M&E plan). Possible problems in procurement rules which may be exacerbating stock-outs should be resolved.

- HII should tie hospital payments to performance on drug availability indicators.
- The Council of Ministers should require the MOH to update the national EML and should approve clear criteria for membership and decision-making on the drug commissions, including the committee to amend the reimbursement list.
- The Government or High Inspectorate for the Declaration and Audit of Assets as appropriate should review drug commissions/committees for financial conflicts of interest, and determine if they are being adequately controlled.

Donor Actions:

- Donors should fund an Albanian civil society group or policy researcher to independently review the composition of drug reimbursement lists for under-inclusion and over-inclusion of drugs
- Donors should fund research of simpler options for setting fixed co-payments for drugs, based on grouping drugs of similar cost into classes or levels.

6. Perform external audits and assure that actions are taken to address findings

External audit allows independent, technically qualified individuals to examine financial reports and the underlying records and systems and to issue a report on whether the financial reports are free of material error (Musau and Vian 2010). Control and supervision reviews by hierarchical or external agencies serve a similar purpose and may include other types of government data such as declarations of conflict of interest and procurement records. In the process of these reviews, fraudulent activities may be detected and reported. Management can also use investigation reports as a guide for systems improvements.

Timeframe: Proposed actions can be implemented immediately and should take 3 months.

Government Actions:

- The Public Procurement Agency or High Inspectorate for Declaration and Audit of Assets should review MOH procurement records to determine if government employees hold positions on boards of bidding organizations or have other financial conflicts which could affect their duties. Adequacy of conflict of interest rules and enforcement should be reviewed in light of findings.
- The Department of Internal Administrative Control and Anti-Corruption (DIACA) or other relevant control/audit bodies (notably the High State Audit) should review past MOH audit findings and determine whether

management has taken action to address findings and reduce risk. If not, MOH should be asked to immediately institutional failings. Donors could help MOH address systems strengthening needs identified through audits.

7. Continue investing in fraud control

HII's strategy of using technology combined with field audits is sound. The agency should continue to adapt control strategies to stay ahead of fraudulent providers. Although problems may change, current areas to emphasize include **control of fake enrolment and utilization figures** and **inappropriate referral of patients to specific pharmacies** where a provider may have a financial interest.

A possible role for development partners could be to support implementation of information technology and adaptation of best practices in fraud control to the new payment systems. Efforts should be made to **quantify fraud control expenditures and return on investment** (in terms of fraud detected and avoided, fines paid, etc.).

Timeframe: These actions can be taken immediately. Funds for information technology investment should be in next budget cycle. Donors could discuss and decide whether to fund special study within 1 month. Study itself should take 3 months.

Government Actions:

- HII should continue adapting strategies to stay ahead of fraudulent providers, with emphasis on verification of actual services delivered and involvement of patients (e.g. sending Explanation of Benefits reports, which would trigger complaint if the patient did not receive the benefit). The agency should consider possible penalties or rewards to motivate hospitals and PHC providers to decrease informal payments and prevent theft of drugs and medical supplies.
- Ministry of Finance should support HII by providing funds for information technology and adapting fraud control to new payment systems, including controls on upcoding.

Donor Actions:

- Donors should support a special study to quantify fraud control expenditures and estimate return on investment.

Annex 1: List of Interviewees

Contacts

Abt Associates, Inc./EEHR Project

Mark McEuen, Principal Associate, Acting Chief of Party

Zamira Sinoimeri, Advisor, former Deputy Minister of Health, former WHO consultant

Agency for the Support of Civil Society

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Xhadi Gjana, Chief of Primary Health Care Services

Bajran Caka, Director of Economics Department

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Gentian Opre, Director, Budget Analysis, Policy and Programming Department

Ministry of Health

Petrit Vasili, Minister of Health

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Open Society Foundation / Albania

Adela Halo, Program Coordinator, EU Integration and Good Governance

Valbona Carcani, Program Coordinator, Public Health

Dorian Jano, Governance Consultant

Order of Physicians of Albania

Dr. Din Abazaj, President

Dr. Shaqir Krasta, General Secretary

Parliament

Fatbardh Kadilli, Member of Parliament, Former advisor on corruption to Prime Minister

Office of the Prime Minister

Mirela Tabuku, Advisor to the Prime Minister

University Hospital Centre “Mother Theresa”

Saimir Ivziku, General Director

University Obstetrics & Gynecologic Hospital “Queen Geraldina”

Halim Kosova, MD, Director

UNICEF

Mariana Bulki, Health Officer

USAID

Stephen Herbaly, Democracy and Governance Team Leader

Zhaneta Shatri, Health Team Leader

WHO

Dr. Ledia Lazeri, Head of Albania Country Office

World Bank

Lorena Kostallari, Operations Officer, Country Office Albania

Other key informants

Two practicing physicians

Two journalists

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