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Planning of the GTZ-Project „Health Policy Consultancy focussing on Health Insurance“

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Coordination with Counterparts and Elaboration of a Working Plan

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Excerpts from the

Mission Report

Final Draft

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1. Executive Summary

The Albanian government is about to complete a new health sector strategy, and some basic decisions on the forthcoming reform have been taken during recent months. There are still some unclear areas regarding the structuring of the future health care system, a sustainable financing model and the role of the Ministry of Health. Decision-makers accord a crucial role to the national Health Insurance Institute, extending beyond mere financing of health services. Due to institutional weakness and other factors, however, the Health Insurance Institute seems to be insufficiently prepared to fill this role.

The GTZ health project aspires to improve the institutional foundations for effective social health insurance and universal health protection in Albania. The SEF action will contribute to developing the Health Insurance Institute as a self-governed public body, supplies approaches for improving transparency and public monitoring, and sharpens the profile of the Insurance Institute as a lobby for the insured. The project pursues three approaches - expansion and consolidation of the Health Insurance Institute as an autonomous, self-administered public body; structuring of the institutional framework of the Health Insurance Institute; and organisation of internal procedures as regards the core tasks of collecting contributions, designing contracts and payment of fees to parties delivering services.

The German contribution comprises sector support/consultancy services to the Health Insurance Institute, sector policy consultancy to the ministries, public authorities and other institutions, as well as approaches towards establishing a supervisory body for the Health Insurance Institute and expanding the representation of the insured in decision-making processes. The project supports the Albanian government in implementing its Health Sector Strategy 2007-2013, specifically as regards improved health financing through a rising proportion of insurance-financed services and enhanced acceptance of income-related social contributions.

Since the elaboration and approval of the project by the German Ministry of Economic Cooperation and Development (BMZ), the general conditions in the Albanian field of health financing and social protection in health have remained widely unchanged. The main challenges the country is facing are still the same as at the end of 2007, the concept and the targets of the project did not require any readjustment or change. However, two draft laws on health care and health financing had meanwhile been presented to Parliament, but they did not get Parliamentarian approval. Even though some political dispute might have influenced the decision of some Congressmen, the rejection was mainly due to some fundamental weaknesses and technical shortfalls.

Decision-makers in the executive and legislative bodies are aware of the importance of quality legislation and agree upon the need to improve the draft laws before presenting them again to Parliament. WHO has undertaken a concerted effort to start goal-oriented technical discussions with the working groups that have been elaborated the draft laws, and the Ministry of Health had immediately responded positively while the Health Insurance Institute needed some time to convince itself of the need of major amendments. It is still an open question if and to which extent legal advice might become necessary within the GTZ health project.

The overall objective of the project is to improve the institutional foundations for a social health insurance scheme in Albania. For achieving this goal, four indicators have been defined:

1. Development of statutes for the organisation of the Health Insurance Institute as an autonomous, self-administered public body
2. Drawing of an organisational chart with detailed description of tasks for the various function areas of the health insurance scheme

3. Elaboration of a needs plan for the necessary training and upgrading has been drawn up.
4. Analysis of the conditions for expanding HII coverage into the formal private sector and mainly the informal sector and submission of strategies for achieving universal coverage

The respective activities and counterparts involved and responsible have been widely defined for indicators 1 and 4, and partly for indicator 3. The work-plan for achieving indicator 2 will have to be further developed in order to have a framework for action and an estimation of resources required. In concrete terms GTZ and HII agreed upon an early assessment of the current state of the art regarding the Albanian health insurance institute. In June 2008, this consultant will apply the InfoSure evaluation and information system to the HII with the support of a national health system expert to be selected. The comprehensive assessment of al relevant areas and tasks of the health insurance scheme will provide the project managers with additional information for adapting the forthcoming activities even more to the constraints and needs of HII.

Mainly two working groups are expected to be established within the project plan referred to indicators 1 and 4. The first will develop proposals and guide the process of developing an adequate statutory framework of HII beyond possible regulations implemented by a future health financing law. And the second group will work on the challenge to extend social health protection to currently uncovered population groups. Indicators 2 and 3 refer essentially to internal affairs of the HII and should be tackled within the institute, of course with some input from international experts and the option to train HII personnel on the job. For all activity, strong commitment and support from the HII directors will be indispensable, and all Albanian counterparts are expected to take increasingly over the ownership of the project activities.

2. Introduction

The short term mission realised in early May 2008 intended to further clarify the current situation regarding the ongoing legislation process in Albania and to update the preliminary findings on the functioning and needs of the Albanian Health Insurance Institute ISKSH. At the same time, the aim of this mission was concretising the strategic planning of the GTZ project on health policy consultancy focussing specifically on strengthening social health insurance in Albania.

The two-fold task required both contacting core stakeholders and participating in a one and a half days planning workshop organised by the GTZ office at Tirana. Representatives of the ISKSH, the WHO office in Albania, the Ministry of Health, the Italian Cooperation and other donors provided the consultant with valuable information regarding the Health Care and Health Financing Laws, current political debates and ongoing discussions that are likely to have effect on the GTZ health financing project. At the same time, this consultant used the various bilateral meetings for informing other stakeholders about the state and the planning of the GTZ project.

The planning workshop was attended by practically the whole leadership of the ISKSH and by high-ranking MoH staff. While the first half-day comprised two presentations held by another German expert and this consultant, the second day was used for planning the project activities, time frames and responsibilities. Even though the group did not achieve to finalise the design a plan of the project, the outcome of the workshop gives clear orientation and defines a series of activities.

Except the first day of this mission this consultant worked in close cooperation with the German CIM consultant who will support the ISKSH during the next two years. The joint activities and the intensive exchange of background information is promising to contribute to establishing a good cooperation between the GTZ project managers, this consultant and the CIM expert in the further development of the project.

The next step planned within the GTZ health-financing project was agreed to be a comprehensive and countrywide evaluation of the ISKSH applying the GTZ assessment tool Info-Sure to be realised in June 2008. In parallel, the health insurance institute will assume responsibilities for the various activities and appoint people in charge of moving them forward. A national expert will be hired in order to give technical support to the managing GTZ office, while this consultant will be available for further support at distance and through time-to-time short-term visits to Albania.

3. Main findings and observations

During the short-term mission realised in early May of 2008, the most outstanding issue was the ongoing legislation process regarding the Albanian health care sector as a whole and the Health Insurance Institute (ISKSH) in particular. As explained in former reports of this consultant (Holst 2007a+b), the small country on the Adriatic coast is struggling for amending a series of partly very old laws and decrees, including the legal regulation of the health system. Compared to the situation during the second half of 2007, mainly two news aspects have come out and changed the situation in health sector. One the one hand, the World Bank (WB) had released the time frame set for passing a new health care and health financing law (see Holst 2007a, p. 16). Albania now can access the initially conditioned grant without having concluded health legislation. On the other hand, the MoH had meanwhile presented two draft laws to Parliament, the Health Care Law and the Health Care Financing Law. However, the legislative body did not accept the proposals and rejected the draft laws to the Parliament's Health Commission for further discussion and amendments.

Based on the rejection by the Parliament, a series of activities have been started. The most important one seems to be the initiative of WHO to make a detailed revision of the two draft laws. Regional WHO office staff has prepared and presented a 20-pages paper with a considerable amount of comments and suggestions regarding various aspects of the drafts (the parts referring directly to health insurance are shown in Annex 7.2). WHO experts are pointing out a series of inconsistencies, the need to regulate activities and to define accountability structures. Moreover, the WHO comments stress mainly the question of what should be part of a framework law and what should better be regulated through additional decrees and rules.

One of the additional critics referred to the fact that both new laws turn out to not be compatible regarding those regulations dealing with both health care delivery and health financing. This is not surprising since authorship and political responsibility for both health laws relied on different groups. Furthermore, no exchange between both editing groups has been reported. While the health care law was drafted by MoH staff with some support from international experts, the ISKSH was leading the editing of the health financing law with support from World Bank consultants. This is interesting for several reasons: To the knowledge of this consultant, WB has not yet achieved major expertise in health legislation, it has in general a rather sceptical view of social health insurance, and most surprisingly WB is until now favouring tax-based health financing for Albania (see Annex 7.3). In this regard it has to be pointed out again that in Albania indirect taxes account for a large proportion of state revenues, there are strong arguments against a tax-financed system. Furthermore, one should remind WB representatives to accept Albania's priority setting as all political parties have agreed to steer towards a contribution-financed health system following the German pattern, and a single payer system.

The separation of labour between MoH and ISKSH reflects to a certain extent the competition between the two relevant stakeholders of the Albanian health system. At the same time, it explains the lack of compatibility between the two health laws under discussion and the different reactions on the WHO suggestions. While the MoH is worried about loosing influence on the ISKSH, the Albanian Health Insurance Institute aims at more independence and autonomy from the ministry. The two-fold law reflects the different points of view and leaves the most relevant issues regarding the future relationship between both players widely vague and unclear. The fact that the draft law defines the Parliament as the supervising body of the ISKSH is a good example for this ambiguity. It remains widely questionable how a legislative body is expected in practice to realise supervising tasks, and who is really meant to be responsible for this. Moreover, it turns out to be highly unpractical to make the Parliament decide

upon all relevant aspects of social health insurance, especially while the draft laws fail to define clearly how to implement autonomy and to operationally self-administration and self-governance.

Not surprisingly, reactions on the WHO initiative have been and are heterogeneous. Obviously the effort made by WHO has created awareness among some stakeholders and induced them to have a closer look at the draft laws. The MoH represented by the vice minister is claiming for improving the present drafts in order to have a high quality law at the end of the process. Accordingly, MoH staff has responded openly to the suggestions for revising the draft law on health care following the WHO comments, and shortly before this mission, the ministerial team that had participated in drafting the law already held a whole day meeting with WHO experts for revising the law framework and the various paragraphs worthy of further discussion and specification. The process seems to be highly appreciated by all stakeholders involved and participants expressed optimism regarding further amendments of the laws.

At the same time, the ISKSH leadership expressed their complete satisfaction with the draft law on health care financing considered as excellent and the best ever elaborated in Albania (comp. also HII - ISKSH 2008, pp. 4f). ISKSH officials only see a certain need for minor improvements, and they expressed to expect essentially the still pending comments of the Ministry of Finance for further amendments of the draft law. Various attempts initiated by the WHO country office to meet the ISKSH directorate and to discuss about the WHO comments had not been successful until the end of this mission. And during the planning workshop several ISKSH directors argued in a way that they take the draft law on health financing as passed and the herein included regulations as granted. Furthermore ISKSH representatives seem to feel a certain pressure to pass and implement the health financing law as soon as possible.

However, according to information from other donors, the Parliamentarian Health Commission recognises the need for major amendments of the health financing law before they are willing to reconsider the draft and to present it again to Parliament. This appreciation is likely to be the most relevant, together with the relaxation of time pressure by the World Bank. Relevant Albanian decision-makers seem to be cautious regarding the maturity of the law proposals and even reluctant to approve it too soon. At the same time, internal and personal challenges faced by the MoH are likely to reduce the options that the ministry puts very high priority on passing the new health laws. The leaving minister will not have the power to enforce the legislative process, and his successor will probably refuse to initiate his mandate with such a delicate issue.

In general terms, capacity and qualification of human resources are major challenges for sector policy in Albania. Informants are worried about the workplace instability and the high turnover rate of the personnel employed by the MoH. The predominating employment policy applied in the public sector affects negatively the qualification of the ministry staff. Moreover, Albanian universities and academies do not yet offer adequate curricula of management what produces an obvious lack of national staff capable of covering administration and managerial tasks required within the ministry and other stakeholders. Due to these conditions, the executive performance, the capacity to define priorities and the preparedness for setting policy guidelines are considered as low. Together with the short-term political influence and the generally weak position of the MoH within the cabinet, the human resources constraints prevent the MoH to play an active regulating and monitoring role in the Albanian health sector. Against this background it is worth mentioning that the responsibility for both the health laws and the GTZ project has finally gone to the MoH while the Prime Minister lately did not play such a visible and active role as during former missions of this consultant.

Compared to the MoH, the ISKSH relies undoubtedly on a more stable staff that is sufficiently prepared for fulfilling the ongoing tasks. However, interviewees stressed the lack of a clear vision within the institution. In fact, the planning workshop held with the participation of practically all department directors showed that all of them are highly committed to their jobs and have acquired considerable knowledge about specific topics: However, the vision of strategic goals and forthcoming challenges offers quite much room for further improvement. This mission did not offer the opportunity to confirm that appraisal, but commitment and mainly planning capacities are very unlikely to be better developed among lower ranking personnel and the staff in regional offices.

Regarding the overall perception if the Albanian health insurance institute, international donors tend to perceive ISKSH as a user-unfriendly organisation that does not facilitate core tasks such as registration and affiliation. The planning workshop underpinned the need for fostering strategic thinking and creating capacities for tackling innovative and forthcoming tasks on the administrative, organisational and mainly technical levels. At the operational level, the institute does not even use well the clinical and other survey data that are available; moreover, the ISKSH has not yet shown a more active participation in the design of ongoing statistical surveys in order to improve availability and quality of demographic, socio-economic and epidemiologic data. And, last not least, the perspective of striving for and hopefully achieving universal health insurance coverage in Albania is currently not included in the priority setting within the ISKSH, neither has it seemed to be an important driving force in the national health policy.[1]

The USAID-financed donor Pro Shëndetit has recently made an expenditure analysis of primary health care in five prefectures. The main findings were a high variety of utilisation and expenditure from one health centre to another, and a generally low efficiency of PHC providers. The average number of daily encounters per facility was 13 in rural and 16 in urban areas. Utilisation is high among patients with chronic conditions who are required to search care at health centre level in order to get reimbursed for the drug recommended by a specialist and formally prescribed by a family physician. The study found essentially four problems with regard to primary health care delivery in Albania: Underutilisation due mainly to the low quality of care, difficulties to access PHC providers, the tradition of a hospital-oriented health system, and the often irrational allocation of human resources to PHC. Health centres are often organised like small hospitals, and ISKSH as the "owner" of health centres all over Albania should revise the number and qualification of the staff employed. Professionalising providers by training management, bookkeeping and planning capacities and increasing the number of nursing personnel are identified as important measures for improving health care delivery. The health insurance fund is also recommended to study additional indicators for resource allocation. The remoteness of facilities and specific socio-economic conditions might improve provider payment mechanisms introduced by former health financing reforms in Albania.

The Italian Cooperation (Cooperazione Italiana) has successfully built up the Unit of Studies and Technical Assistance for Institutional Support in front of the MoH headquarters. The Unit was officially inaugurated at the end of November 2007 and started to work in January 2008. The concept and work plan were finally approved by the Italian and Albanian governments in the way they were presented (comp. Holst 2007a, pp. 13f + Annex 12.4). Even though the practical cooperation with MoH staff has currently become a little bit more difficult due to the reconstruction of the MoH building, the Unit has initiated activities and established working

[1] For further information regarding the ISKSH and major challenges for implementing efficient social health insurance in Albania see the former reports of this consultant (Holst 2007a, pp. 21ff; Holst 2007b, pp. 9ff).

contacts with several stakeholders in and outside the MoH. Besides the Director General for Support Services, Mr. Bardh Spahia, the Unit has obviously established good working relations with the Parliamentarian Commission on Health. However, it still seems to be a major challenge to involve key-persons and high-level decision-makers.

That will certainly be one of the reasons, why the Unit implemented by the Italian Cooperation is highly interested in collaborating with and to involve other donors in the health sector, especially with regard to bringing expertise and know-how to Albania. The director encouraged the GTZ office in Tirana and the stakeholders of the GTZ-financed health project to work together. There is explicit willingness to support workshops and specific consultancy tasks foreseen during the project by capacity-building, organisational and financial means.

4. Recommendations

4.1. Capacity building, assessment and autonomy

The current political situation is characterised by a number of changes that have either occurred or are generally expected to happen in the near future. Exchange of key personnel, controversial political interests and the forthcoming general elections in 2010 increase the level of uncertainty and make it difficult to predict what will happen within the next 12 months. Against this background it is very likely that counterparts might be repeatedly distracted by cyclical events and loose track of the medium and long-term goals and priorities of the GTZ health project. This is quite normal and uses to occur and different countries and settings. However, GTZ-staff supported by international and national experts and hopefully also by the CIM expert contracted by the HII should make the effort to keep track with the overall objectives and the four main indicators according to the work plan elaborated together with HII staff.

Within the imminent project activities, a comprehensive and in-depth assessment of the ISKSH is strongly recommended in order to provide all stakeholders and counterparts involved in the project a reliable overview on the status quo and to define a clear base-line for all activities foreseen and/or required. ISKSH and GTZ generally agreed upon the early application of the InfoSure Health Insurance Evaluation and Information System as one of the first steps of the GTZ health project in Albania. The InfoSure methodology offers a series of options including monitoring and self-assessment, but it seems recommendable to opt for a comprehensive application in the beginning performed by an international expert with relevant experience in applying the tool and a national co-evaluator with excellent knowledge of the Albanian health system and good facilities to get in touch with all relevant groups. Furthermore, (s)he should dispose of internationally backed experience in health system research and health financing and be widely independent from the institution evaluated. As the selection of the national co-evaluator has turned out to be crucial for the assessment outcomes, this report includes a draft version of potential terms of reference for the Albanian InfoSure co-evaluator (see Annex 7.7).

Qualification and preparedness of staff is still a major challenge and sets some constraints to the further development of the Albanian health sector. This is certainly more worrying and more difficult to resolve at the MoH, but forthcoming challenges are likely to demonstrate the lacks of capacity within the ISKSH, especially in view of the broader scope and the new tasks emerging from the increasing relevance of the institute. While the MoH is planed to withdraw stepwise from some responsibilities according to a clearer separation of functions, the workload and the requirements of ISKSH will rise. In this context, the GTZ health project Albania has a large potential to create awareness and to better prepare the institution and the personnel for future challenges and needs.

Relevant stakeholders agree upon the need to implement a fully autonomous and self-governed social health insurance fund in Albania. The model referred to varies according to specific experiences of decision-makers involved in the process, but the model frame is clearly linked to Central European SHI systems, let them be the Austrian, French or German model. However, Albanians do not want to simply copy another system and tend to criticise bilateral donors that want to implement things in the same way they are functioning in the respective donor country. At the same it has to be clearly said that not much discussion and rationing seems to have occurred regarding the development of an Albanian model of SHI. The design has to fit into the overall political framework and has to be in line with basic legal and political conditions in the country. The search for the “Albanian model” has not yet been concluded, if even started. This finding underpins the need for the analysis of potential mod-

els and policy advice regarding the set-up and implementation of a SHI-model suitable to Albania. Thus, the GTZ project should also focus on more general health insurance policy issues and accomplish the concrete activities for enhancing capacity and capability of the ISKSH by policy advice.

4.2. Donor coordination

In the broader field of health policy advice, coordinated activities and joint efforts with other bilateral donors are promising to increase the options to achieve some noticeable impact. Mainly the Unit of Studies and Technical Assistance for Institutional Support should be taken into account when it comes to plan international and also national workshops and to organise visits of international experts and working stays of Albanian staff in European SHI institutions. The fact that the Unit is still enforcing lobbying activities and struggling for a higher degree of recognition by decision-makers will certainly have positive influence on the willingness to participate actively in the preparation, organisation and financing of workshops and conferences. Some more policy-oriented consultancy activities fitting into the GTZ-project framework and required for achieving the overall goals might be shared by the Unit of Studies and Technical Assistance, and parallel activities that have the potential to support project activities should be explored.

The further development of the health care and health financing laws might open a window of opportunities for including legal advice into the GTZ health-financing project in Albania. However, such an approach is only conceivable if it is strictly in line with other donor activities in the field, especially with the WHO initiatives on health legislation. To a certain extent, recommendations from German or other European health legislation experts are very likely to coincide with the suggestions made by WHO. Moreover, consultancy with regard to the health financing law has a high risk of doubling efforts in a situation where the capacity of the Albanian counterpart to absorb advice and support appears to be doubtful.

4.3. Heavy burden of out-of-pocket payment

From the point of view of German Technical Co-operation it seems to be necessary to stress an essential problem of health care financing in Albania. In line with core positions of WHO, ILO and several other European donors, the German approach in social protection focuses on both universal coverage and fair financing (BMZ 2005, p. 13). The majority of scientific and other publications about the Albanian health care system (e.g. Hotchkiss/Hutchinson 2005; Vian/Burak 2006 and others; comp. also Holst 2007a, p. 11f) show that out-of-pocket payments amount a considerable part of health expenditure. Due to the longstanding practice, both providers and patients have become used to pay over and under the table before they can access health care. However, broad international experience shows that especially high co-payments have a series of negative effects, preventing many people from seeking care in time and enhancing the risk of impoverishment due to the need for health care. Direct payment is the most unfair way of paying for health care (WHO 2000, pp. 96f, 113; Saltman et al 2002, p. 73f), and cost-sharing discriminates against the sick and especially against the poor (Whitehead et al 2001). And in the context of publicly financed health systems, out-of-pocket payments reduce the level of financial protection and, thus, the effectiveness of prepayment schemes.

Against this background, the fact that official and unofficial co-payments are widely accepted in Albania presents a major challenge to implementing quality social protection that really prevents people from high expenditures and from deterring health care for economic reasons. In the comments on the Albanian health legislation WHO has expressed serious preoccupation regarding potential lacks of financial protection of the poor and other vulnerable populations from the impoverishing effects of out-of-pocket health expenditures (WHO 2008, p. 8f).

On the other hand, well-regulated and reasonable co-payments might support the abolition of under-the-table expenditures during a transition phase, even though country experiences concerning this matter are not unique. In any case, the GTZ-project should carefully watch further discussions about cost sharing, create awareness about the many undesired effects of out-of-pocket payments, and try to enforce the financial protection objective of the health system.

4.4. Challenges of the forthcoming EU-membership[2]

Neither the draft health care law nor the health-financing law are adequately taking into account the requirements of the EU conformation process. The Albanian Government and all relevant stakeholders agree upon the country's willingness to join the European Union as soon as possible. Therefore, a series of requirements have to be met within the next years, including the harmonisation of the pre-existing legislation and the adaptation of new laws to EU standards. The Albanian EU conformation office has rejected the two draft laws presented by the MoH as incompatible with general European requirements. According to information gathered during the mission, no further attempt to adapt the draft laws to EU standards has been undertaken so far. In view of the apparently low willingness to revise the health financial law the need to make Albanian legislation compatible with European requirements and standards might offer an important opportunity for recommending another revision of the draft laws under discussion.

The EU is first of all a trans-national market aiming at promoting international trade and exchange of goods. Even though the EU Charta of Social Rights contains some aspects that build a kind of framework for national health policy, social policy remains responsibility of the member states. In this sense, the Treaty of the European Community (TEC) states the following: "Community action in the field of public health shall fully respect the responsibilities of the Member States for the organisation and delivery of health services and medical care. In particular, measures referred to in paragraph 4(a) shall not affect national provisions on the donation or medical use of organs and blood" (EU 2006a, Art. 152.5).

However, concerning the potential health system requirements for Albania becoming a EU member there are further elements to take into consideration, especially with regard to universal coverage. In this context it has to be stressed that universal access to high quality healthcare service is a common and shared value among the Member States and the European institutions. To this end, a key document is the "Council Conclusions on Common Values and Principles in European Union Health Systems 2006/C 146/01" (EU 2006b). Herein the Council of the 25 Member States defines the meaning of universality, access to good quality care, equity solidarity as follows:

"The health systems of the European Union are a central part of Europe's high levels of social protection, and contribute to social cohesion and social justice as well as to sustainable development. The overarching **values** of universality, access to good quality care, equity, and solidarity have been widely accepted in the work of the different EU institutions. Together they constitute a set of values that are shared across Europe. **Universality** means that no-one is barred access to health care; **solidarity** is closely linked to the financial arrangement of our national health systems and the need to ensure accessibility to all; **equity** relates to equal ac-

[2] This chapter is largely based on information accumulated and provided by Mrs Marianna Cavazza, lecturer on health economics, health policy, public health and health care organisation at the European Institute for Public Administration, Antenna Milan, Italy. The consultant is highly grateful for the support given by Mrs Cavazza and especially for selecting the references to the EU legislation, conclusions and communications applicable to health care systems and universal social protection in member states. For helping the Albanian counterpart to become more familiar with the regulation to take into account for applying for EU membership, this report includes the precise bibliography plus respective internet sources.

cess according to need, regardless of ethnicity, gender, age, social status or ability to pay. EU health systems also aim to reduce the gap in health inequalities, which is a concern of EU Member States; closely linked to this is the work in the Member States' systems on the prevention of illness and disease by *inter alia* the promotion of healthy lifestyles" (EU 2006b, p. 2).

These principles are mentioned as well in the updating of Lisbon Agenda (2005)[3], where universality, equality, solidarity and efficiency in national healthcare services are among the conditions required for promoting economic growth. Making reference to the goals of Lisbon 2000, a preparation document of 2004 underlines how a universally accessible healthcare system has a crucial impact on social cohesion:

"The provision and funding of health and long-term care are key elements of the economic and social modernisation strategy launched in Lisbon in March 2000 for three complementary reasons.[4]
Social cohesion is reinforced by access to quality care based on the principles of universal access, fairness and solidarity. Improving access to care is acknowledged to be a way of mobilising the potential of the EU's workforce in the context of a shrinking active population. Recent studies show that care policy should be seen as an active employment policy tool, as it increases the social and occupational integration prospects of jobseekers. However, the draft "Joint report on social inclusion" shows that the most disadvantaged groups have more, and more serious, health problems: for example, 16 % of those in the bottom income quintile say that they are in poor health, compared to 7 % in the top quintile. These people often find it more difficult to have access to care, because of long waiting times, high treatment costs in relation to their income, complex administrative procedures and, more generally, insufficient prevention (screening, vaccination) […]." (CEC 2004, p. 5).

Furthermore, according to the Guidelines approved in March 2002 by the Barcelona European Council and the Joint Report adopted by the European Commission (EC) and the Council in March 2003, the EC proposes joint objectives for supporting the development of healthcare systems in the enlarged Union. Especially one of them will become a crucial challenge for Albania and the ISKSH in a single payer system:

"[..] 3.1. **Ensuring access to care: universal access, fairness, solidarity**
One real success of European care systems has been to make high-quality care accessible to all. They must continue to provide a safety net against ill health-accident- or old age-related poverty, for both the beneficiaries of care and their families. Universal coverage must be based on solidarity, according to the structure of each system, benefiting in particular those on low incomes and those whose state of health requires intensive, long or expensive care, including palliative and end-of life care. However, access difficulties still exist for certain groups and individuals, compromising their social and occupational integration ability. Moreover, inequalities in the regional distribution of care facilities or inadequate supply compared to need can lead to abnormally long waiting lists. Staff recruitment and management difficulties can cause similar problems. Care systems must therefore develop a care package which is sufficient and well adapted to the needs of the population." (CEC 2004, p. 7).

[3] As far as the relevance of a universal, equal and efficient healthcare system, the Communication to the Spring European Council from President's Commission Barroso, "Working together for growth and jobs. A new start for the Lisbon strategy", COM(2005) 24, Brussels 02.02.2005, makes reference to this previous document: The Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions, "Modernising social protection for the development of high-quality, accessible and sustainable health care and long-term care: support for the national strategies using the "open method of coordination" Brussels, 20.4.2004 COM(2004) 304 final.

[4] The other two complementary reasons are „total employment" and „demographic aging" (J.H.).

According to these documents, the EC guarantee of universal and fair access to healthcare services based on the principle of solidarity can be described as a basic condition for healthcare systems of EU member states. There are some constraints and difficulties, but these concern mainly the erosion of the depth and scope of public system coverage (e.g. cost-sharing arrangements and benefit packages of both tax financed health services and public health insurance schemes), or cultural and geographical hurdles. However it has to be pointed out that the goal of universal coverage is not under discussion in the European Union and in the Member States.

In their statement of 2006, the Health Ministers of 25 EU countries recognize that "[…] different Member States have different approaches to making a practical reality of these values [universality, access to good quality care, equity, and solidarity]: they have, for example, different approaches to questions such as whether individuals should pay a personal contribution towards the cost of elements of their health care, or whether there is a general contribution, and whether this is paid for from supplementary insurance. Member States have implemented different provisions to ensure equity: some have chosen to express it in terms of the rights of patients; others in terms of the obligations of healthcare providers. Enforcement is also carried out differently - in some Member States it is through the courts, in others through boards, ombudsmen etc." (EU 2006b, p. 2). And the health ministers express clearly the need to back the shared social policy goals by sufficient financial means, independent from the underlying health financing system: "It is an essential feature of all our systems that we aim to make them financially sustainable in a way which safeguards these values into the future." (ibid.).

In Europe the portability of entitlements has been achieved gradually, step by step: German pensioners moving to Spain may now benefit from local health care services, and Italian tourists travelling to France or Greece are entitled to access health care services. Moreover, migrant workers are protected by a comprehensive array of arrangements and directives. Regulations regarding national social protection schemes are not only subordinate to the common objective of social cohesion, but also to another core EU principle, the freedom of movement (Weber et al. 2005, p. 31). The freedom of member state inhabitants to move along the EU enjoying the same rights and duties as national citizens has a series of implications. Among others, they tend to enforce standard social protection system regulations and guarantees in place in all member states in order to prevent host countries from carrying treatments costs due in their territory.

In concrete terms Albania will be facing the above described requirements of universal coverage and others within a medium time frame, latest when it becomes a new EU member state. Then Albanians can travel and work – at least after a certain period of transition – to and within all other EU countries. If an Albanian travelling through France or Denmark or working in Germany or Spain falls sick, (s)he is entitled to access health care in the hosting country, but somebody has to bear the treatment costs. In order to prevent discrimination against EU-foreigners in the member states and to ensure access to health care in the whole EU territory, the member states have implemented the portability of social protection within the EU since the 1st of July of 2006. In order to arrange portability of social rights for Albanians throughout the EU, somebody has to take care of the health costs incurred in other member states. If the state does not want to be the "last resort" for covering all health care costs outside the country and inside the EU, other arrangements have to be found probably through the existing health insurance schemes like ISKSH. And these arrangements have to be based on universal coverage for having all Albanians entitled to health benefits all over the EU.

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7.6.2. InfoSure Overview Presentation

InfoSure Presentation

InfoSure: Health Insurance Evaluation Methodology and Information System

A Concept for Collecting, Processing and Publishing Data on Health Insurance Systems

Developed by the GTZ Sector Project „Elaboration and Introduction of Social Health Insurance Systems in Developing Countries", together with the Institute of Tropical Medicine (ITG), Antwerp, Belgium and the AOK Health Insurance Fund of Germany

Dr. Jürgen Hohmann, Dr. Bernd Schramm, Christian Herzog, Dr. Dr. Jens Holst

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InfoSure Product Description

What is InfoSure?

- An Information System (collecting and publishing data)
- An Assessment Tool (understanding principles and functions)
- An Evaluation Tool (measuring performance and success)
- A Tool for Health Insurance Analysis and Comparison
- A Tool which facilitates Professional Consultancy
- A (Best) Practice Database on the Internet

- Qualitative, context and process oriented information
- Multilingual (English, French, Spanish)

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InfoSure Key Benefits

InfoSure supports …

- the design, implementation and survey of health insurance schemes as well as their continuous monitoring
- the discovery of innovative approaches and structural weaknesses while assessing health insurance schemes
- analysis and reporting of key functions and developments within and between health insurance schemes
- consultancy and evidence-based action in health care financing and health insurance

- InfoSure is suitable for many further purposes and can be adapted to explore a wide range of issues

www.infosure.org

InfoSure Components

What does InfoSure offer?

- A clearly structured questionnaire for collecting quantitative and qualitative data (off-line entry tool and print version)
- Quality check, editing and translation facilities after data entry, but before processing the information
- An analysis tool to assess and evaluate recorded information and generate reports
- An internet-based database to publish case-studies, reports and international comparisons
- A word-wide platform to exchange practical and scientific experience amongst policy-makers, administrators, insurance managers, stakeholders, academics, and many more

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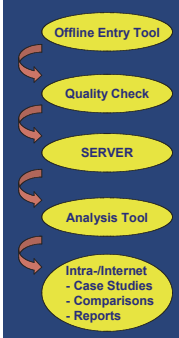
InfoSure Evaluation Workflow



Data entry

Quality check, translation

User administration, editing of the questionnaire preparation of analysis

Report generating tool and evaluation

Publication of case studies, reports and comparisons in the intra- / internet

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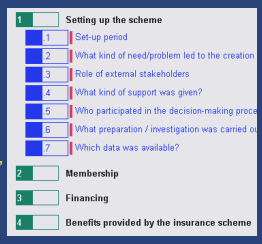
InfoSure Data Entry

Offline Entry Tool

- Questionnaire with 150 questions in 16 areas
- Main focus on qualitative information
- Text, multiple choice and statistical questions
- All relevant information covered, i.e. planning, setting up the scheme, membership, financing, benefits, risk management, services, legal issues, administration, health care provision, provider payment, financial/statistical profile
- Internal verification, links and comparisons
- New questions and categories can be added flexible without external support



- The outcome of the data entry process is a case study!

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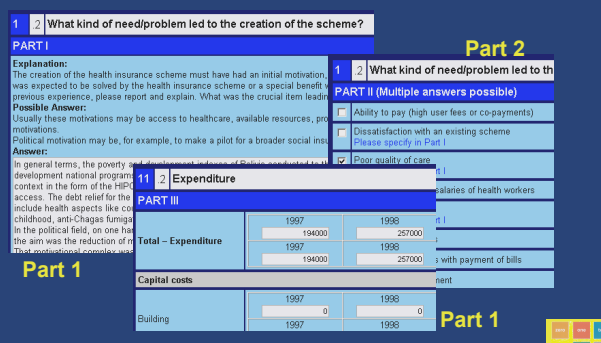
InfoSure Questionnaire



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InfoSure Analysis

Analysis of Health Insurance Data

- ? Case studies published in the Intra- / Internet
  - ❋ Publication settings to be defined in the user administration, e.g. confidential data can be hidden or released only for selected users
- ? Generating of reports and templates for reports
- ? Comparison of different case studies

Benefits:

- ? Reports available in HTML and XML (easy view in the Internet), but can be copied into Word as well
- ? Immediate publishing possible

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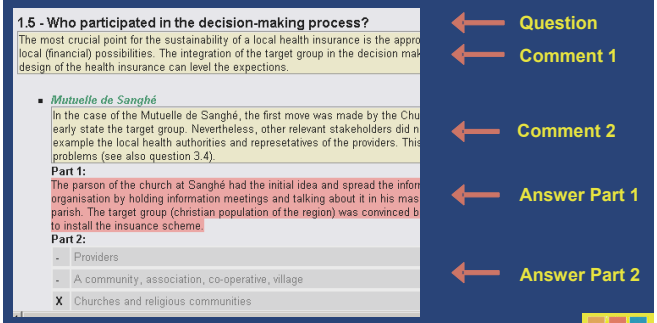
Report Structure (Example)



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Conducting an InfoSure Evaluation

Alternatives

- ? Evaluation with an Experienced InfoSure Evaluator (both data entry and analysis on the server)
- ? Self-Evaluation of Health Insurances (at least data entry, the analysis should be done by a trained person)
- ? Using only the InfoSure questionnaire (electronically or as hardcopy) to plan, design or assess a health insurance scheme

Case Study Duration

- ? 5-10 days needed for one case study

Adaptation for other Purposes (e.g. Life Insurance)

- ? 10 days needed for technical adaptation and new server installation
- ? Modification of the questionnaire (can be done individually)

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