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IMPLEMENTING A NATIONAL HEALTH SERVICE MODEL IN THE ALBANIAN HEALTH CARE SYSTEM

Ermira Qosja* and Ertila Druga**

*Tirana European University; Economic Faculty, Management and Economics Department. Blv., Tiranë, Albania

**Tirana European University; MBA Student, Blv. Tiranë, Albania;

Abstract

This paper is an attempt to analyse the progress of the actual reforms in the Albanian public health sector and to present an evaluation of its results' perception. The reforms of the last three years in the albanian health care system aim to frame it under a national health service model, and specifically under the NHS of the United Kingdom. In this paper, the NHS of the United Kingdom model is presented as one of the world's most successful models based on: the economics of health, effectiveness and efficiency, social stability, welfare and solidarity. Through a qualitative research methodology, which enabled the evaluation of the opinions and the perceptions of the interviewers and the sample, a research question and a hypothesis was tested through descriptive statistics and text analysis. The data was gathered from the literature, the secondary sources, online questionnaires with physicians and doctors and information of national and international expertise on the issue. In the paper, we tested the possibility of a successful implementation of a national health service model by analyzing the medical profession-state relationship. The hypothesis was not supported by the study analysis as it was concluded that the disbalanced relationship affects the successful implementation of a national health service model (NHS) to the Albanian Health Care System.

Keywords: health system, national health service model, medical profession-state relationship.

I. Background

The current reform in the health care sector aims to implement the National Health Service model in the Albanian Health Care System, as it is qualified as one of the best health care services in the world in terms of the quality, access and efficiency¹.

“Our challenge in this respect stands in restoring citizens' lost confidence in the health service, ensure them the deserved protection through universal health coverage and provide professionals with suitable conditions to deliver qualitative services.

¹ NHS comes top in healthcare survey <http://www.theguardian.com/society/2014/jun/17/nhs-health>

*We view health care as a public good and fundamental development factor. We shall build a qualitative and healthcare system that offers full access and is financially sustainable. Through a radical reform we will offer universal healthcare coverage for all the Albanian residents without excluding anyone just because they do not avail of the required financial means.*²

The first sector reforms proposals were presented by the Ministry of Health in June 1993, in *A new policy for the health care sector in Albania*. Along with several basic policy goals, two objectives were identified: 1) to prevent further deterioration of basic services; and 2) to transform the health care system into a financially sustainable system that can be managed efficiently and produce effective services. The further reforms of 2004, 2007 and 2009 were focused on: 1) reforming regulation; 2) reforming health financing and resource allocation; 3) reforming health services production.

The Ministry of Health still remains the major funder and provider of health care services in Albania, and devotes most of its efforts to health care administration, rather than policy and planning. The health care system in Albania remains highly centralized and hierarchical, despite some decentralization.

Historical background. The Albanian healthcare system has no more than a century lifetime. The Ministry of Health was established in 1944, and it had only an organizational structure of 21 employees, and a total of 175 Albanian and foreign physicians practicing in the whole country. Before 1944, most of the population did not have access to health care facilities, which were mainly based in urban areas. Access improved after 1945 when a health care system was developed based on the Soviet "Semashko" model. After the Second World War, Albania adopted the economic model features of the Soviet Union, and the healthcare system was considered a "non-productive" sector and thus a low priority. Health services were organized in programmes controlled from the centre. The quality of services was poor, there was little continuing medical education, and hospitals were kept overstaffed, the salaries were low. In 1987, health expenditure in Albania was estimated to be 3.0% of GDP, compared to a CEE average of 2.8% and an EU average of 7.3% (Tomes, 1994).

In the early 1990s, Albania began the transition from a centrally planned to a market economy. The dissolution of the Communist model was accompanied by the collapse of its institutions and structures and the health care system faced great difficulties: severe budget constrain, disruption and damage caused by civil disturbances, and a population with urgent health needs. A key problem facing the government after the transition in 1992 was finding the financial resources to maintain essential health services, given the very small government budget. Albania also experienced a severe brain drain; unofficial data indicate that during the period 1990–1999, 40% of the professors and researchers at Albanian universities and research centres left the country.

Private medical practice and private insurance were legalized in 1992, and the private health sector is continually expanding, particularly through the increasing number of specialized outpatient clinics and some hospitals; but hospitals, polyclinics, health centres and health posts remain publicly owned.

² Prime Minister's Office, Public Services, Healthcare <http://www.kryeministria.al/en/program/public-service/healthcare>

For the size of its population, Albania has few trained health care professionals in comparison to other European countries. Furthermore, the distribution of health care professionals remains concentrated in hospitals. Albania had 4494 doctors in 1999, or 1.36 doctors per 1000 population; this number dropped into 1.15 doctors per 1000 population in 2007³.

Aims and objectives. The main aim of this research paper is to analyse and evaluate the success' factors which will contribute to a successful implementation of the current health care reform and to present some findings and recommendations, taking into great consideration also some possible limitations.

The objectives of this research paper are: 1) to identify and present the basic principles and organisational features of a National Health Service model; 2) to analyse the relationship between the medical profession and the state.

Research question: *"What does prevent / facilitate the successful implementation of the current health care reforms toward a National Health Service model in the Albanian health care system?"*

Central hypothesis: *"The successful implementation of a National Health Service Model in the Albanian Health Care System requires a balanced relationship between the state and the medical profession."*

Limitations

The paper presents some objective and subjective limitations, despite of the serious and committed work done. The most important objective limitation is related to the time context. The health care reform is still under its implementation. Other limitations are related to the limited resources (time, people, and financial support).

Some limitations are related to the sample. The ideal sample of the study should have been a stratified sample with all physicians and doctors following the local/administrative health directorates and all care levels as well.

Qualitative methodology recognizes that the subjectivity of the researcher is intimately involved in scientific studies. In this paper it is related with the content of the questionnaire and interpreting data as well. The translation of the questionnaire may contain bias and also the answers of the respondents.

There is any few possibility the respondents may be not physician or doctor, part of public healthcare service either. The online version of the questionnaire enables to control only the time, date and some technical (internet protocol) of the answers.

³ Health System Indicators in Albania, <http://open.data.al/sq/lajme/lajm/id/282/titull/Tregues-te-Sistemit-Shendetesor-ne-Shqiperi>

II. Literature review

Many countries have tried to reform their health systems. As the existing health systems could not reach the desired performance, they were obligated to reconstruct them in order to improve. Health systems are complex, with many components and actors which interact and are related to each other (Atun and Menabde, 2008). They are one of the most complex and comprehensive administrative and policy systems and in constant development.

The best health care systems are the ones that need less money and, at the same time, cure more patients and prevent more illness. As defined by his work in *National Health Systems of the World*, Roemer's analytical model places health systems into 3 base categories: the entrepreneurial model, the mandated insurance model, and the NHS model. They are all organized by the wealth and the degree of government involvement. The NHS is a market-minimized, national health service model. This model is "characterized by universal coverage, general tax-based financing, and national ownership and/or control of the factors of production." (Sanders, 2002). In NHS countries, the government itself is most likely to own the health care resources and employ the health care staff (Moran, 1990)

One of the distinctive organisational features of the NHS in the United Kingdom is the 'double-bed' relationship between the state and the medical profession (Klein, 1990). This relationship provides a powerful interpretation of the way the government and its institutions interact with doctors and their representatives. The relation between the state and the medical profession creates a situation of mutual dependency (Webster, 1998). On the one hand the state acts as a monopoly employer; effectively members of the medical profession became dependent on it not only for their own incomes but also for the resources at their command. On the other hand the state became dependent on the medical profession to run healthcare services and to cope with the problems of rationing scarce resources in patient care. Klein (1990) suggests that the reason why the double-bed relationship in NHS of the United Kingdom has been so enduring is because of its very real symmetry. The state, because of the medical profession's compliance in running and rationing care, receives a 'best buy' healthcare system, remarkably inexpensive in international terms. Doctors, in return for running the NHS and for rationing care, have received an assurance of employment within it.

The relationship between the state and the medical profession can also be characterised as being one of national accountability with local paternalism (Greener and Powell, 2008). The Ministry of Health is to be held accountable for the public delivery of healthcare, but the doctors are to be responsible for delivering health services at every level. Doctors are remarkably insulated from central policy makers because of their medical expertise and the autonomy this gave them, but also because of the lack of ability of politicians or central policy makers to be able to measure or examine what the doctors are actually doing. Equally, policies could be made centrally, but had to be implemented locally by doctors in order for the delivery of care to change, and given the lack of formal management control over doctors, the reality of the situation is that doctors are probably more accountable to their profession than to the organisation that employ them.

As Klein (1995) describes the role of the government, 'it could educate, it could inspire and it could stimulate', but it could not control. In the case of the state, to concede autonomy to the medical profession is also to delegate responsibility for rationing. Inevitably, it would seem, the

management of mutual dependency and the resulting conflict depends on the political system-that is, political context, style, and conventions that shape the relationship between the state and the profession (Greener, 2009)

III. Methodology

A descriptive research design was used to describe and evaluate the perceptions of the current reform outcomes and effects. A structured questionnaire with 10 questions in total was framed. It was completed online by the persons previously contacted in the period February-June 2015.

Sampling. The survey targeted all physicians and doctors in all three care levels (public health care) in five main districts. The population of all doctors and physicians in these districts is nearly 60% of all doctors and physicians in Albania. This way, the results of the questionnaire from this sample theoretically will not present large deviations in case we should consider the whole population of doctors and physicians in Albania. The questionnaire was disseminated via emails, containing a short presentation of the research and the link in it.

There was not enabled any information regarding the participation of the respective districts, but the most important fact is the participation of the doctors of the tertiary care level, that are all part of Tirana district. Their participation was import due to the fact that doctors of the tertiary care level are highly specialised, with an enormous medical, management and leadership experience.

The questionnaire. It is structured in four parts: Part I: General Information, five questions with eighteen items; Part II: Individual motivation, one question with seven items; Part III: Organizational culture, one question with eight items; Part IV: perceptions of the outcomes, one question with ten items. The four sections will contribute to data findings related to: 1) demographic and social data; 2) individual motivation; 2) organizational culture and 4) individual and organizational perceptions on outcomes/effects of the reforms.

The content of the questionnaire was shaped by the following factors/considerations: 1) Building the survey on a theory-driven basis, integrating different research disciplines and interests; 2) the content of the questionnaire therefore links with central research concepts in different disciplines such as public administration, public policy, organization theory, management theory and psychology; it allows for a broad spectrum of research papers and analyses based on the resulting data; 3) Allowing for analysis of different levels/perspectives: it combines questions at meso-level (organizational level) and micro-level (individual)

The questionnaire design process took as reference for methodological issues, topics, issues and operationalization of variables of interest other public administration surveys, healthcare public administration included. COCOPS⁴ research reports and surveys on public sector reforms in Europe were the main models of reference. The variables of specific research interest were individual motivation, the perception of organizational culture and the perception of the outcomes/effects of the current reforms in individual level and organizational level.

⁴ Coordinating for Cohesion in the Public Sector of the Future <http://www.cocops.eu/>

The questionnaire was based on a set of key principles regarding the methodology and its development:

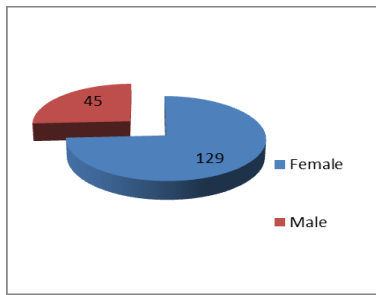
- A questionnaire with no more than 10 questions to be realized also through the website www.surveymonkey.com.
- Collecting three types of information/data: a) socio-demographic information; b) perceptions on individual motivation and organizational culture; c) perception of the reforms outcomes/effect.
- Focusing on current reform practice rather than past reforms and placing less emphasis on normative assessments ('How it should be') and views on the future of the public health sector reforms.
- Referring to a standard period of these last 3 (to 5) years throughout the entire survey when time periods are mentioned in the questions, therefore corresponding with the timeline of the latest reform in the healthcare sector in Albania.
- Employing 7-point scales for answers would allow for sufficient variation in responses.
- The 'Don't know / cannot answer' option was used scarcely; it was decided to preferably allow respondents to skip questions rather than allow for this 'opt-out' alternative and thus to complicate the later analysis of results.
- Employing only one open question, to avoid interpretation issues during the data validation and analysis phase.

IV. Findings and results

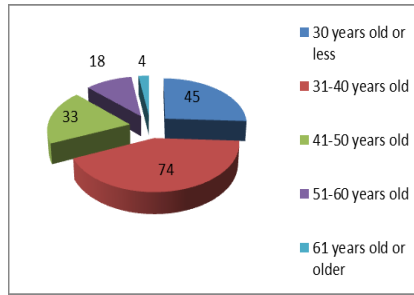
The following sections provide the descriptive statistics for all data gathered from a sample of n=174.

Socio demographic characteristics of the sample. The sample was highly predominated by females (74.14%/ 25.86%). The majority of the physicians and doctors were between ages 31-40 (42.53%), having a postgraduate degree –Master (58.05%), and they were actually working in the hospital care - secondary healthcare level (54.65%). As for the work experience in years, all categories rated almost the same, except those of more than 20 years (9.77%).

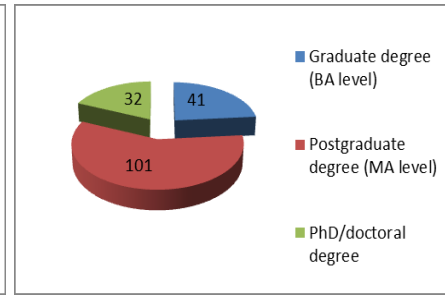
Graphics 1-5 present all these socio-demographic characteristics of the sample.



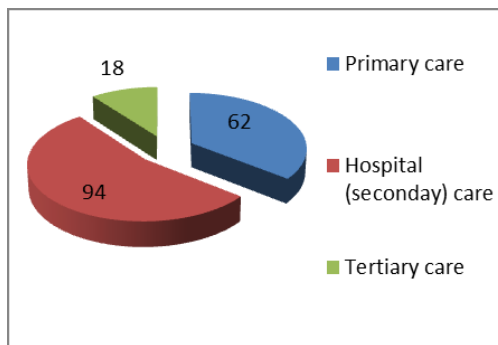
Graphic 1. Gender



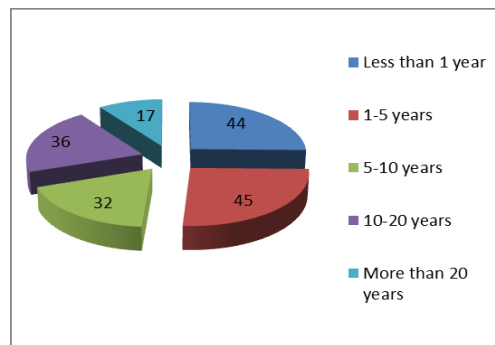
Graphic 2. Age



Graphic 3. Educational level



Graphic 4. Level of care



Graphic 5. Work experience

The section of individual motivation (intrinsic, extrinsic). The answers of this section were based on personal values and views and were not related to immediate work experience and environment.

When asking “*How important do you personally think it is in a job to have...*”, the most rated answers were “*Interesting work*” and “*Workplace security*”. Using a likert scale 1 to 7 their respective weighted averages were 6.27 and 6.21. The third most rated option was “*High income*” having an weighted average of 6.11. Less rated answers were “*Good opportunities for advancement*” and “*Doing something that is useful to society*”, while the least one was “*Independence in deciding the times of the day when I work*” (5.05).

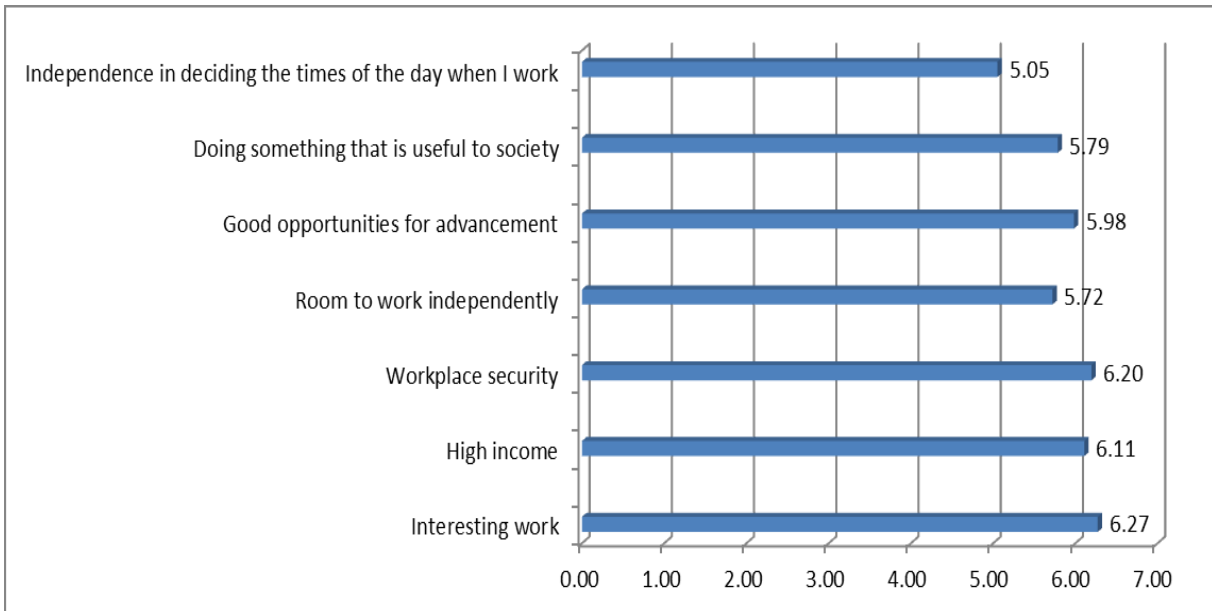


Chart 1. Individual motivation

The section of organizational culture. In this section, the interest is in how the job and the work experiences along a number of dimensions are perceived. The answers were based on own experiences with the current job and observations of the current organization. We wanted to know ‘how you perceive what is’, not ‘what you think should be’.

When asking about “*People in my organization...*” the most rated choice was “*Willingly share information with one another*”, scoring a weighted average of 4.54 in a likert scale of 1 to 7. There were also moderately rated the choices “*Share and accept constructive criticisms without making it personal*”, “*Have a high team spirit*” and “*Engage in open and honest communication with one another*” scoring correspondently weighted averages of 4.29, 4.11 and 4.33. The lowest weighted average, scoring 3.85 was “*Share the same ambitions and vision for the organization*”. The ratings of the organizational culture were significantly lower than the ratings of individual motivation.



Chart 2. Organizational culture

The section of perceptions on reform effects and outcomes – individual and organizational level. This section analyzed the data related to the perceptions of the current outcomes of the reform in individual and organizational level. The main focus was in the views and experiences related to the health reform and how it had affected this sector. Some questions required individual assessments regarding certain phenomena, other questions requested just based on observations opinions.

The most rated answer of *“When thinking about my work and the organization I work for...”* was *“Things were better in the days when people stayed with one organization for most of their career”*(5.91) and the least rated one was *“I am highly paid for the work I do”* (3.71).

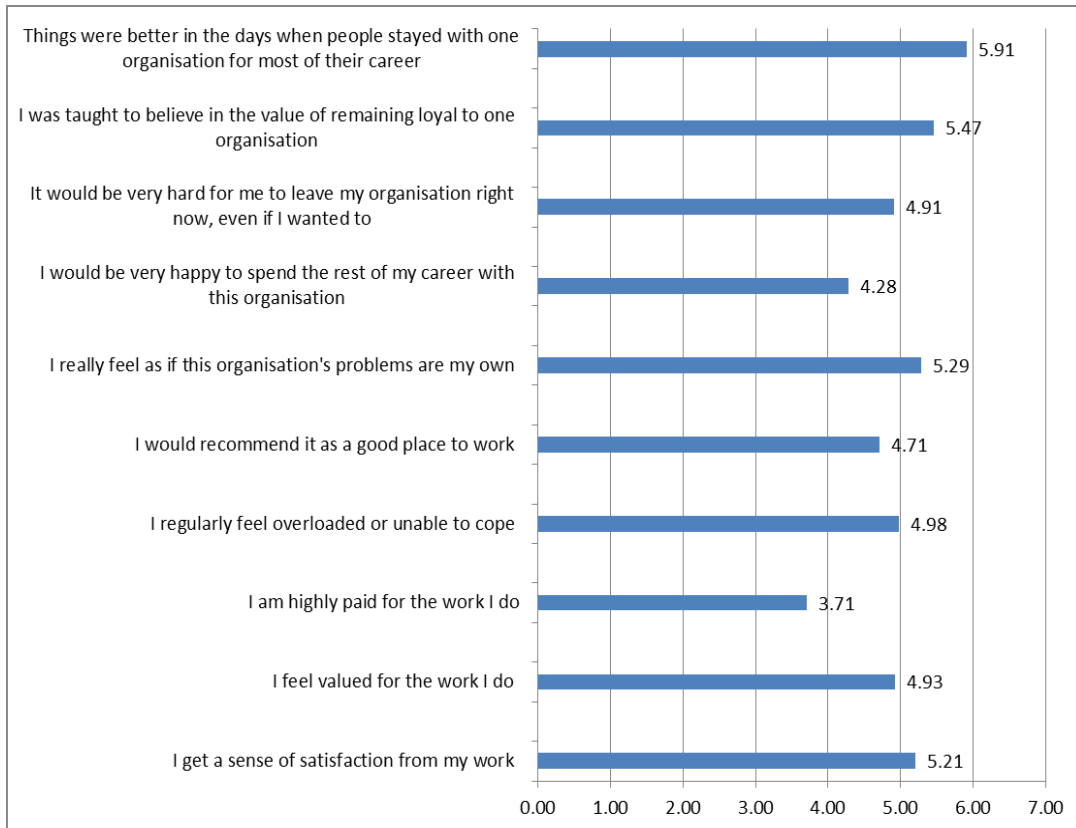


Chart 3.Perceptions on reforms outcomes

The section of direct evaluation of the health sector reform performance. Using a likert scale from 1 to 10, the direct evaluation of the reform performance scored at a low level of 5.86 which is evidentially just “a passing grade”. The ratings of the perceptions on reform effects and outcomes, in individual and organizational level were diversified and somehow more contradictory; while the direct evaluation of the reform performance is significantly low.

Compared to 3-5 years ago, how would you say things have developed when it comes to the current public health care reforms?	Worse - 1	2	3	4	5	6	7	8	9	Better - 10	Total	Weighted Average
		17.65%	1.96%	11.76%	1.96%	13.73%	7.84%	9.80%	1.96%	11.76%	21.57%	
	32	4	20	3	24	14	17	3	20	37	174	5.86

Table1. The direct evaluation of the perception of the reform performance

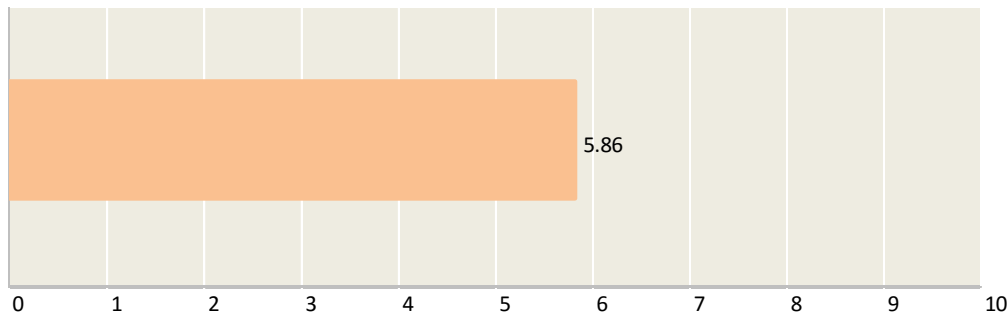


Chart 4. The direct evaluation of the perception of the reform performance

V. Discussions

The findings of this paper did not support the empirical hypothesis *"The successful implementation of a National Health Service Model in the Albanian Health Care System requires a balanced relationship between the state and the medical profession."* The relationship medical profession - state resulted to be disbalanced, affecting the outcomes of the reforms and therefore the successful implementation of a national healthcare service system in Albania.

The physicians and the doctors appear to have a *high individual motivation*. They need to have an interesting job, to be professionally and financial secure; what they need less was just the flexibility in their working time schedules. The interest for promotion, advancement, work independence and decision making was evaluated in between scores.

The ratings of *organizational culture assessment* scored lower compared to the individual motivation ones. These lower ratings indicate a weak organizational culture, affecting so the work performance with final results toward a lack of interest from the part of the state in a mutual and successful relationship with the medical professionals. The best rated answers in this section were related to the advancement of the professional aspect and the team spirit but doctors appear to appreciate less sharing the same vision and ambition with the organization.

The perception of the outcomes (so far) of the reform values the long stay of the people in their organisation. In a different context, this evaluation shows stability and durability, but in the current situation of the public sector employment policy or in a corrupted environment of gaining

a post as a public servant, this assessment is presented as a requirement or a necessity. Of course, the easiest perception of the reform outcome is the low financial evaluation.

Moreover, *the direct evaluation of their perceptions assessed a clear low score.*

VI. Conclusions & Recommendation

The best reforms outcomes are directly connected with the trust the patients and the society should have in the public health care services and in the medical profession. This fact should be a priority in the further development of the public health care service in our country. A public health reform should put first its citizens and this is the only way to have a health care system with a high quality and which will be safe, accessible, effective and efficient.

In order to have efficient reforms, a strong collaboration and involvement of the staff is required. They are considerably important in taking part of the reforming process and in decision making as well. Qualified human resources, training programs and well prepared healthcare managers in all levels of the health care system are required as well.

Some recommendations are related to the research aspect of the paper. A future evaluation of the same outcomes/ variables, especially at the time when the reform will be fully implemented will present a distinctive evaluation and also to a dynamic view of the all process. A future research on the low evaluation about (doctors) sharing the same vision and ambitions for the organization and any correlated variable will be an interesting research theme.

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