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MINISTRIA E SHËNDETËSISË
DHE MBROJTJES SOCIALE

STRATEGY ON THE DEVELOPMENT OF PRIMARY HEALTH CARE SERVICES IN ALBANIA

2020-2025

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Table of content

DECISION
No. 405, dated 20.5.2020

ON THE APPROVAL OF THE PRIMARY HEALTH CARE SERVICES DEVELOPMENT STRATEGY IN ALBANIA 2020-2025

Pursuant to Article 100 of the Constitution, upon proposal of the Minister of Health and Social Protection, the Council of Ministers

DECIDED:

1. To approve the Primary Health Care Services Development Strategy in Albania 2020-2025, according to the text attached to this decision.

2. To charge the Ministry of Health and Social Protection, its subordinate institutions and local self-government units with the implementation of this decision.

This decision shall enter into force upon its publication in the Official Journal.

PRIME MINISTER
Edi Rama

Foreword by the Minister of Health and Social Protection

The work of the Albanian Government during the past 7 years has laid the ground that would enable our country to design the first national Strategy for Development of Primary Health Care, constituting the baseline document supporting and materializing the steps for implementing the Albanian Government's program, with the ultimate goal of providing universal health coverage.

For the first time, through this strategic document, we have introduced the vision and challenges for the next four years as regards the integration of social care services with primary health care services in Albania in accordance with European models, wherein health care and social care are inextricably linked.

In addition to improving the horizontal integration of clinical care with community social services, the strategy also provides for the vertical integration of health services, in order to ensure ongoing care at all levels of health care, starting from the family and community level to tertiary services, while always focusing on patients' health, thus resulting in a cultural shift that increasingly refers to the patient and not just the doctor.

Through this primary health care system reform, the Albanian Government aims at preventing disease and maximally reducing bureaucracy, during treatment of chronic diseases, improving the quality of service and patient care, for prevention has a direct impact on ensuring a more comprehensive, effective and affordable medical service.

This strategy will guide the work of health authorities towards increasing the health personnel performance, improving their motivation and continuously enhancing resource efficiency and service quality across the country, by substantially eliminating differences in the quality of health service delivery in cities and remote areas in the country.

By implementing this strategy, the specialization of family doctors will be made possible through the establishment of family medicine centers that will constitute the first step in the patient treatment itinerary; the role of nurses will expand and the category of community nurses will be established; clinical protocols will be adapted and measurable service quality standards will be applied; the infrastructure improvement of all health centers will continue, thus also allowing for coordination with neighboring countries in border areas.

I wish to note that the implementation of this strategy will be the next challenge that the Ministry of Health and Social Protection will undertake in the future, as well as the continuation of efforts and policies to date in order to designate more resources to disease prevention services and hospital care burden reduction, therefore fostering a new approach culture towards medical care.

Lastly, I would like to thank the team that made this document possible, in particular the doctors, nurses and interest groups for their valuable contribution, as well as the World Health Organization and the Swiss Government for their support during the drafting of this document.

Ogerta Manastirliu
Minister of Health
and Social Protection

Drafting of the strategy

The Strategy for the Development of Primary Healthcare Services has been drafted by a working group composed of the following:

- Mrs. Mira Rakacolli, Deputy Minister of Health and Social Protection – Head
- Mrs. Merita Xhafa, General Director, Directorate of Social and Health Policies, MoHSP – member
- Mrs. Andoneta Njehrrena, Director, Directory of Programs, Standardization and Harmonization of Regulatory Frame, MoHSP – member
- Mrs. Denada Seferi, Director, Directory of Development Programs of Health and Social Protection, MoHSP – member
- Mr. Erol Çomo, Responsible Unit of Policies and Strategies for Health Development, MoHSP – member
- Mrs. Albana Fico, Director of Public Health Institute, member
- Mrs. Albana Adhami, representative of Compulsory Health Insurance Fund

The working group was assisted by the technical group composed of the following:

- Mrs. Rudina Degjoni, Consular to the Minister of Health and Social Protection
- Mr. Alban Ylli, Public Health Institute
- Mrs. Artenca Çollaku, Representative of organizations operating in primary healthcare sector
- Mrs. Valbona Iljazi, Family physician
- Mr. Besim Nuri, Mrs. Ehadu Mersini, Representatives of Health for All Project
- Mr. Gazmend Bejtja, Representative of World Health Organization

The drafting process was supported by the following international experts mobilized by Health for All Project (HAP):

- Cristina Vladu, Public health expert
- Adrian Pana, Public health expert

The Action Plan was outlined with the support of IPH expert, Mrs. Albana Ahmeti.

1. Part one: Strategic context

1.1. Document introduction and purpose

Primary Health Care is considered a fundamental service in the Albanian Health System efforts to control diseases and protect all population health.

The Albanian Primary Health Care (PHC) has been established for the first time but is based on a well-established tradition. It states that the majority of the population's contacts with the health system occur at the Health Center level and many health problems are addressed by general practitioners or even nurses in primary health care facilities. However, demographic and epidemiological changes, ever-increasing expectations for health care, linked with the high risks of increasing inequalities, require more support, adaptation, and reform in primary health care.

This strategy will determine the way of preparing the primary health care system that will better and efficiently address the health needs of all communities and categories of populations. Better access of vulnerable communities to health care services will be achieved through better horizontal integration of the various specialized professionals working at the community level, as well as vertical integration (continuity of care between PHC and hospital/ other specialty areas). New service models will be set up to meet the most pressing needs identified at the community level, such as non-communicable disease prevention and control (NCDs), home care for the elderly, models of care through digital technology, especially in remote areas, etc.

The PHC strategy aims at improving the reputation, self-esteem, and motivation of Primary Health Care workers. Lastly, the strategy will serve to achieve the political vision of a National Health Care System oriented towards universal coverage.

The strategy presents a new vision of the PHC by setting clear priorities, objectives and interventions. It does not detail every activity enabling gradual change that will not affect the benefits already achieved by the system and operational structures.

1.2. Legal and institutional framework

1.2.1. The General legal framework, based on which the strategy is structured and implemented

Pursuant to law no. 10107, dated 30.03.2009, "On Health Care in the Republic of Albania" as amended, the PHC in Albania is provided through a network of professionals and health institutions, based on the Family Medicine principles, while the Ministry approves these services organization and functioning rules. The Ministry decides on the PHC institutions distribution, the staff composition, as well as on each health center management and accountability.

Law no.10 138, dated 11.5.2009 "On Public Health", defines the public health functions and services as well as the government's role in the assignment of responsibilities among institutions. Some public health services are provided by means of the PHC institutions.

This strategy addresses some challenges in the new context created after Decision no. 419, dated 4.7.2018, "On the Establishment, Organization and Functioning of the Health Care Services Operator" which has created a new organizational and managerial PHC basis. The National Health Care Services Operator and its regional branches are a new health system reality responsible for the PHC, public health and hospital services organization and provision.

The strategy takes into account the PHC institutions and services financing rules based on Decision of Council of Ministers no. 737, dated 5.11.2014, "On the financing of PHC services from the compulsory health insurance scheme".

Also, this strategy determines the Health Services Package need for adaptation, in the public PHC funded by the Compulsory Health Insurance Fund approved by Decision no. 101 dated 4.2.2015.

Law no. 8652, dated 31.7.2000 "On the organization and functioning of the local government" (as amended by law no. 9208, dated 18.3.2004) also has an impact on the PHC support, especially regarding the health centers infrastructure maintenance.

The PHC development strategy is also established pursuant to other documents of the Government of Albania, particularly the National Health Strategy 2016-2020, NCDs Control Plan of 2016-2020, the Health Promotion Action Plan 2017-2021, etc.

The strategy for the development of PHC services of 2020-2025 is drafted pursuant to the National Strategy for Development and Integration, 2015-2020 (Component: 'Social Capital Investment, and the 'A stronger and more accessible Health Care System' goal) in accordance with the vision "Albania – a strengthening democracy, towards its EU integration with a competitive, stable and sustainable economy, that guarantees fundamental human rights and freedoms".

This strategy is also in line with international standards and documents based on the principles of universal health care coverage under the World Health Organization European Framework for Action on Integrated Health Services Delivery' 2016.

It is an appropriate response to the United Nations Sustainable Development Goals (SDG):

Goal no. 3. Ensure healthy lives and promote well-being for all at all ages.

1.2.2. PHC system governance, organization and capacities challenges

Health Care governance and organization in Albania aims to guarantee the public accountability of the institutions, while at the same time encouraging the motivation of health care professionals and greater efficiency in service delivery.

The country is being subjected to significant structural reforms: the merging of health and social policy-making institutions at the national level, an institutional reform that has led to the creation of new institutions, such as the National Health Care Operator with its 4 regional directorates which are undertaking a series of functions in health care planning and administration in the primary and secondary health care services field. These developments have followed a broad territorial reform integrating small communities into larger municipalities as well as performing a decentralization process that aims to enhance power and accountability at the local government level.

Over the last decade, there have been an increased number of visits at the PHC services, driven by growing health needs, better access to services and changes in health behavior. However, although in 2017 there were 7,942,742 visits performed at PHC institutions with an average of 2.7 visits per capita per year, still the indicator remains low compared to other European countries.

There are 1,538 general practitioners working in the 413 health centers in Albania, (the number of specialist physicians is 287) and 6,864 nurses and laboratory technicians. Meanwhile there are 1656 positions planned for physicians and 7017 for nurses. The PHC physicians perform an average of 11.3 visits per day, with significant differences between urban and rural areas.

The geographical distribution of the population has changed significantly while the territorial organization of the PHC has not changed much in the last 30 years. Health centers and outpatient clinics are unevenly distributed

across the country, with large cities having health centers that cover a population ten times larger than those in rural areas. In Tirana or other major cities, the capacity of health centers is greater in terms of medical staff and some special services, such as: child and woman's consultation center. A territorial redistribution of health centers is needed and, in order to create models of a new comprehensive and integrated family medicine and social support services, in areas with greater needs and sufficient capacities, a new level of the health care center level will be piloted; Family Medicine Center.

Sustainable improvement of the PHC institutions infrastructure remains a challenge for Albania. Pursuant to the Law on Local Government, Municipalities are responsible for the PHC facilities construction, rehabilitation and maintenance, along with other education and promotion activities at the local level, but these only take place in very few administrative areas. In fact, most HCs and lands they are built on are owned by the Ministry of Health and Social Protection. The Ministry has launched an investment program in health centers across the country, but in order to have sustainable results, the new infrastructure needs to be maintained and standards in this area need to be constantly improved. For this, as previously mentioned herein, a new commitment of municipalities is needed as far as PHC is concerned, along with the harmonization of all actors, and the provision of sufficient resources at the local government and PHC institutions level, etc.

Research indicates that financial difficulties due to health care are more likely to occur when public health spending is lower than the gross domestic product (GDP) and direct out-of-pocket payments account for a relatively high percentage of the total health spending. (Xu et al. 2003; Xu et al., 2007; WHO, 2010). Public spending on health in Albania accounts for 2.9% of GDP, compared to the average of 3.7% for middle- and upper-income countries in the European WHO region.

The health services quality improvement is an ongoing process. During 2018, there were some important developments related to the NES quality in Albania. This way, the Health Centers' accreditation process has started and some additions in the Health Care Law have been approved, which provide for the application of clinical audit. For this legal requirement fulfillment, it is necessary to review and approve fact-based guidelines and clinical protocols and applicable in the conditions of our country.

1.2.3. Challenges related to the epidemiological transition and the appropriate management of non-communicable diseases

The PHC in Albania has traditionally been organized to meet the mother and child health challenges, and today must adapt to the specific needs associated with increasing the NCD burden.

Non-Communicable diseases constitute the biggest burden for the Albanian health system and the entire Albanian society. They are the most important cause of premature deaths and healthy life years' loss in our country. This group of diseases has been subject to significant growth over the past two decades, a trend that is expected to continue in the future as a result of increasing life expectancy and aging of the Albanian population. A significant proportion of these diseases can be managed and controlled at the PHC, in the most cost-effective way and without requiring hospitalization or hospital treatment. The largest number of cases registered with the PHC are composed of two groups of diseases; circulatory or cardiovascular diseases (where the vast majority is constituted by hypertension) with almost 389,000 cases and endocrine ones (where the vast majority is constituted by diabetes) with approximately 135,000 cases.

It should be noted that some chronic health problems such as hypertension and diabetes, although classified as actual diseases, are often considered risk factors for other life-threatening circulatory diseases. For this reason, controlling them can prevent the burden of these diseases on the health system, as well as unhealthy

life years and premature deaths. It must be a comprehensive control in order to be effective; primary prevention by supporting healthy living, early diagnosis and good management through counseling and treatment.

A steady increase in the number of cases treated by the PHC services for hypertension and diabetes is noticed in Albania. The basic health check up program for people aged 35-70 has significantly contributed to the increased identification and follow-up of these two health problems in the PHC. Thus, for 2015 (when this program started) there was an increase of over 30% for diabetes and over 12% for high blood pressure, compared to the previous year (NCD 2018 Report). However, the Demographic and Health Study (ADHS 2018) shows a very high prevalence of uncontrolled hypertension in the population, while there is still a very large proportion of individuals with hypertension not aware of having it. It seems that the early identification and effective management of hypertension is a primary challenge for the PHC in Albania.

Also, the PHC must adapt to the specific needs of the vulnerable populations (isolated elderly, persons with disabilities, the Roma community, etc.). They are more exposed to health risks and are the categories least protected from the negative consequences of these risks. Currently, the PHC services for vulnerable groups are separate from social services. Both services need to be more coordinated and integrated.

1.2.4. Strategy developing methodology

This strategic document is based on a multidimensional analysis of the PHC system in Albania and the factors related to it. In this context, a PHC specific assessment based on the model of the 'WHO European Framework for Action on Integrated Health Service Delivery' and on the monitoring instruments proposed by the European WHO Center for the PHC has been carried out. 73 health professionals of the PHC (directors, physicians, nurses) were contacted and interviewed in 46 health centers and outpatient clinics in different areas of Albania, which covered a population of more than 180,000 inhabitants. Also, 25 key informants were interviewed in 15 relevant institutions at central and local level.

The strategy was developed during a 6-month work by an interdisciplinary group with specialists in various PHC areas. The group's work has been supported by international experts in the field.

1.3 The primary health care services vision in Albania

1.3.1. PHC vision

The PHC services that protect and improve community health by preventing disease, providing fact-based services, proactively addressing inequalities, covering vulnerable groups, and reducing the need for avoidable hospital services. Services are provided regardless of gender, nationality or economic status.

Principles/values on which primary health care services are based

- Respect for the patient/citizen: In primary health care facilities, everyone is treated with due attention, decency and due care; services focus on patients and they support their health;
- Teamwork: Health care staff collaborates to ensure transparency and do the best for their patients.
- Quality: The practice is based on the principle of evidence-based medicine and aims at continuous quality improvement.
- Inclusiveness: Communities and consumers are involved in the strategic management and performance evaluation of primary health care services.
- Continuity of care: primary health care services guarantee linkage and coordination with other health system levels, community and social services.
- Cost-effectiveness: primary health care prioritizes clinical services and practices that provide low-cost control of health problems.

Aims of the Strategy

This strategy aims to:

Increase the quality and range of PHC services, which will:

- reduce the number of referrals to secondary, tertiary and emergency services;
- increase patient satisfaction; and
- Enhance the reputation of family doctors.

Prepare the health system for potential challenges, including increasing service needs and addressing shortages of health workers by promoting the role of nurses in PHC health centers as well as community nurses.

Provide integrated health and social services to respond to the individual needs of vulnerable individuals and groups.

Improve access to services and provide coordinated and continuous health care through collaboration with medical specialists.

1.3.2. Strategy Impact Indicators

1. Increase of healthy life expectancy by 1 year (years of life without disease);
2. Increase of PHC services users by 10% (number of visits);
3. Reduction of hospitalization cases for treatable diseases (Hypertension, diabetes, asthma, COPD, depression, etc.) by 5% at the PHC;
4. Reduction by about 10%, of the ratio of people who do not use the PHC although needing services, in certain population categories.

2. Part two: Policy goal and specific objectives of strategy

Strategic priority areas for PHC development in Albania

9 priority areas for PHC development in Albania have been identified:

1. Institutional Strengthening for better PHC Governance

4. PHC Information System

7. Determining, piloting new types of services and geographical redistribution

2. Human resources in the PHC system

5. Basic PHC Services for Universal Health Coverage

8. Continuous improvement of PHC service quality

3. Health infrastructure and technology in PHC facilities

6. Financing and Contracting for Universal Health Coverage

9. Management of PHC facilities

For each priority area, a brief contextual analysis has been presented, overall and specific goals have been identified, and interventions or activities for change have been listed. Some expected results have also been provided for each objective.

2.1. Policy 1. Improving the institutional capacity for better governance of PHC

Context and issues to address

Governance and organization of PHC facilities have to do with their modus operandi, management, inter-institutional relationships within and outside the health system, outreach rates, as well as the integrated operation of all primary health care services to enable the delivery of the best quality care package considering the national resources.

The structural reform in health has led to the creation of new institutions, such as the National Health Care Operator with its 4 regional directorates which are undertaking a series of health planning and administrative functions in the area of primary and secondary healthcare services. As these are newly established institutions, they need to be strengthened in order to better plan and manage the PHC system. Also, their role will be further expanded to support PHC facilities. Furthermore, the National Health Strategy 2020 provides that municipalities need have more competencies and be more responsible for issues such as: planning the PHC facilities network, including rehabilitation of premises, purchase of equipment.

The integration of health care and social support has already been achieved at the central level of health management. The integration will extend to primary health care services, especially, given that the government has the priority of providing universal coverage, thus, treating the most vulnerable with a basic package of services. Traditional primary health care services will incorporate more elements of social protection while improving coordination between the health system and social services at the municipal level. Meanwhile, the broad territorial reform has led to the integration of small communities into larger municipalities and is expected to lead to a decentralization process that aims to provide more power and accountability at the local government level, including health responsibilities.

The mission of PHC is to focus on community health and not only on individual health. An important part of the services provided in PHC facilities should aim at disease prevention and health promotion. Many public health programs, for the control of both communicable and chronic diseases (vaccination, education, surveillance, screening), can reach communities only through PHC services. The efficiency of the relationship between the new local health care units and the health centers will be further improved in the field of disease prevention and assessment of vulnerable or risk groups.

Overall Objective I: Improving the institutional capacity for better governance of PHC

2.1.1. Specific objective 1 of policy 1

Building the organizational capacities of the Ministry of Health and Social Protection and the Health Service Operator at the central, regional and local level regarding the strategic planning and performance monitoring of PHC.

Interventions/actions

- Draft/develop strategic institutional development plans together with an Institutional Development Plan (Business Plan) for the National Operator (NO) /4 Regional Operators (ROs) that will include:
  - The mission, vision, and objectives of each organization
  - Development and consolidation of relevant structures and systems
  - Definition of programs and services
  - Staff competence development
  - Budget
  - Communication competences
- Prioritize capacity building to monitor and measure the primary care services performance. This will include in particular:
  - Standardized indicator and data models relevant to monitoring the PHC services performance,
  - Operational methodology to support clinical audits of health centers,
  - Spirit of team evaluation, transparency, and feedback
- Build and consolidate an integrated health information system at the primary health care and public health services level. To this end, it is necessary to reach an agreement with the Compulsory Health Insurance Fund on the roles, co-operation and avoidance of duplicate information collected from health centers. This health information system will allow for fast and dynamic recognition of the health indicators and services situation, enabling the Operator and its structures to plan interventions according to real needs. Also, the information system will enable the return of processed data (feedback) to the health centers and local units, so that the latter can compare the health and performance indicators and take the necessary actions for their further improvement.
- Strengthen the Operator's infrastructure. The operator and its regional branches will be staffed with the necessary personnel. Strengthening human capacity and creating a pattern of teamwork will be the immediate objectives so that the new Operator structures can perform their functions at the optimal level. At the same time, the operator will be provided with all the necessary infrastructure and logistical capacity to perform its tasks and accomplish its mission.
- Integrate primary care services with social services.

EXPECTED RESULTS

- The NO will have sufficient institutional capacity to develop regional and local strategic health plans enabling the participation of HCs and other stakeholders and providing process orientation;
- Health information system from the health centers to the Operator will be built and strengthened, in support of the process of drafting strategic and operational plans and in support of improving health indicators and service provider's performance.
- The infrastructure and capacities of the National Operator and its agencies will be built and operated,
- The NO will achieve the integration of preventive public health measures and monitoring of NCDs within the PHC system.
- A model for monitoring the performance of PHC will be built and operated

2.1.2. Specific objective 2 of policy 1

Strengthening, improving and expanding the capacities of the Public Health institutions network

Interventions/actions

- Designate institutional roles that would provide better support to HCs by local health care units in the field of public health; health promotion, vaccination, screening for cancers, surveillance of communicable and non-communicable diseases, prevention of outbreaks, performing basic health screening, risk assessment for NCDs, and identifying vulnerable groups
- Tailor information on health status and disability in such a way as to allow health assessment not only by demographic but also social, (e.g. homeless/unemployed) and ethnic and cultural categories (e.g. the Roma community).
- Strengthen capacities for operational research in the fields of preventive and primary health care services, in particular, the application of qualitative assessment methods, to understand and address the difficulties faced by vulnerable groups in accessing health care services.
- Build and strengthen public health laboratory capacity to support the prevention and control of potentially epidemic communicable diseases and of environmental risks.
- Establish, consolidate and operationalize chronic disease prevention programs, in line with the National Health Strategy priorities and integrate them into primary health care structures, with particular involvement of nurses and other health care providers.

EXPECTED RESULTS

- Institutional responsibilities related to public health will be coordinated and operational between IPH, NO, Local Care Units (LHCUs) and HCs
- Public health priorities will be better identified and integrated into PHC practices
- New tools and forms of cooperation between PHC and LHCUs will be applied

2.1.3. Specific objective 3 of policy 1

Strengthening the local government units' (LGUs) support role towards PHC

Interventions/actions

- Intensify the cooperation of the Ministry of Health and Social Protection and its subordinate structures with local government bodies with the aim of increasing the involvement and capacity building of local government in the planning, design, and implementation of infrastructure maintenance projects for primary health care services.
- Review the role, budget, and provision of municipal support for the HCs maintenance in their territory, based on the applicable legislation.
- Mobilize the local government to actively contribute to improving the health status of their communities through the organization of joint health promotion programs with the LHCUs.
- Strengthen the cooperation between the Operator and the LGUs on the coordination of social protection services provided at the municipal level with those provided at the health care centers maintenance.

EXPECTED RESULTS

- LGUs will be more committed to the primary health care services processes; LGUs shall benefit from legal provisions and relevant budgets to provide sustainable support to HCs.
- Primary Care Centers will ensure efficient maintenance of their infrastructure through the LGUs' administrative, financial and technical support.
- Social services subordinate to municipalities will provide services in close coordination with social services provided at the health centers level.

Strategic Change: Greater Governance Role of the Health Operator and Local Care Units for PHC Services. A new level of institutional coordination and sustainable growth of community health-related functions in PHC services

2.2. Policy 2: Human resources in the PHC system

Context and issues to address

A motivated and task-oriented staff is essential to providing the highest quality of primary health care services. PHC in Albania needs staff distributed according to the community health needs, capable of adapting to the increasingly complex and growing demand for health care services driven by rapid demographic, epidemiological and social change. No reform could achieve its goals without addressing the gap and needs in human resources, in particular of doctors and nurses working in the sector.

PHC staff faces several key issues:

Most PHC physicians are general practitioners and not specialist family doctors. Postgraduate education in Family Medicine does not benefit from the similar rights enjoyed by other specialties, which make it difficult for a general practitioner to pursue specialized family medicine training. Meanwhile, there are many categories available at the health center level for health workers (pediatric GPs, adult GPs, GPs for all age groups, physicians for healthy children in the consulting service, physicians for healthy women in the consulting service, specialists, etc.), there are no clear job descriptions/ToR for the different categories of healthcare workers (doctors and nurses). The presence of multiple categories of health professionals in HCs can lead to fragmentation of PHC services and more harmonization and elimination of traditional divisions between specialties (e.g. pediatricians visiting adult and vice versa) is needed focusing on holistic family

medicine; a new categorization according to international standards is also needed.

Basic training for both PHC nurses and physicians is conducted in hospitals, with little opportunity to encounter specific PHC health problems.

Continuing Medical Education (CME) courses are tailored to the associations that provide them rather than to the real needs of health care workers in PHC facilities. Often, they are carried out in the context of activities, conferences, and last shortly. There are no long-term and permanent CME providers nationally focused on the implementation of new clinical guidelines, protocols, and standards. Also, training courses in PHC management are missing while there is a pressing need for HC medical managers. PHC facilities and other health providers are not investing sufficiently in training their health practitioners. New services that need to be developed under this strategy require the development of guidelines and practice protocols, and health professionals will need to be trained on new knowledge and skills.

What is noticeable in the PHC system is a large number of nurses, although their distribution varies widely (from 7.2 to 34.7 per 10,000 populations). Their potential to improve PHC capacity and preventive outreach activities is currently underutilized. The basic services package in Primary Care generally describes the competencies required for family doctors, but not for nurses. It is necessary to improve the training of nurses and revise their role so that they can take on new tasks and play a greater role in maintaining and improving the community's health.

The pressure of external and internal migration remains a threat to the future, reflecting a decrease in the number of physicians in primary health care. There is also a steep decline in physicians who choose to specialize in Family Medicine (in 2019 only 2 physicians selected Family Medicine). The specialty in Family Medicine is based solely on hospital practice and has failed to relate to the primary care practice. The challenge will be addressed by tools that aim to enhance the quality of qualification, motivation and performance; the presence of general practitioners in remote areas will also continue to be supported.

Overall objective II: Supporting the development of sustainable and quality human resources as regards PHC

2.2.1. Specific objective 1 of policy 2

Supporting general practitioners in becoming family physicians

Interventions/actions:

- Establish an accredited mid-term and non-stop training program for general practitioners under 45, to be developed in several phases (bridge program in family medicine). This program will enhance the clinical skills of general practitioners by aiming to cover the range of services expected to be provided by a Family Doctor according to the European standards.
- Apply policies to encourage new graduates to become family doctors; equal treatment with other medical specialties, priority recruitment criteria for specialized physicians, application of professional development Incentives for family doctors, including the possibility of majoring in a subspecialty, harmonization with occupational medicine to allow bi-contractual employment, payments during the specialization program, etc.
- Apply policies to encourage young graduates to become family physicians; equal treatment to other medical specialties, priority recruitment criteria for specialized physicians, apply Professional Development Incentives for family doctors, include the possibility enhancing a subspecialty, harmonization with occupational medicine to allow work with two contracts, payment during the specialization program, etc.;
- Reduce fragmentation of existing PHC delivery models (for children and women, adults, etc.); coordinate various categories for PHC professionals with international standards (ILO-description of personnel categories). A smaller number of physicians

will be able to provide pediatric services, mother and child consultation services, prenatal care, mental health care, emergency services, etc. Nurses and midwives will also play a greater role in preventive care, childbirth or the pregnant women follow-up.

EXPECTED RESULTS

- By 2025, 50% of physicians working in PHC will be family medicine physicians
- The gap between the different categories of family doctors will be narrowed
- Professionally motivated family doctors, higher quality patient services
- A growing number of young physicians who choose family medicine

2.2.2. Specific objective 2 of policy 2

Improving basic education programs for PHC professionals

Interventions/actions:

- Adapt the training of PHC professionals by providing them with the opportunity to be trained in conditions similar to the HC daily practice (training of trainers from the selected HC)
- Develop a Masters Program for family and community nurses (within the HAP 2 project)
- Establish a network of University Centers of Excellence in Family Medicine as a support to improve the professional training of physicians and nurses in undergraduate and postgraduate programs in family medicine. This means promoting selected health centers at the university level where health services are provided and where the first and second cycle students conduct university internships under the guidance and supervision of family doctors and nurses. This new form of education could be achieved through cooperation between the Ministry and the University of Medicine. The first center will be set up as a pilot intervention and the gained experience will allow further expansion of the model.
- Establish long-term postgraduate training programs for general practitioners and family doctors create training modules for new skills (medical emergencies, mother and child consulting centers, prenatal care, palliative care, mental health care, family care, case management, etc.)
- Upgrade the education quality during the specialization in Family Medicine; interns will be taking care of patients in internal medicine and emergency medical care; they will spend 1 year of clinical experience in internal medicine, 6 months in emergency care and 1 year in Family Medicine Excellence Centers or other accredited teaching centers.

EXPECTED RESULTS

- 70% of general practitioners will be certified as family doctors by 2025 and will have their training at the HC during their basic education program
- Family doctors and nurses will become trainers in basic education for PHC practitioners
- 50 family nurses operating in PHC will have completed the new Master Program in Family and Community Nursing.

2.2.3. Specific objective 3 of policy 2

Improving the role of continuing education in order to support critical developments of PHC services provision

Interventions/actions:

- Increase the provision and expand the range of continuing education activities. Adapt the CME curriculum and training activities to real PHC needs (new profiles - e.g. family/ palliative care/mental health skills/guidance on risk assessment and control of NCDs and monitoring of NCDs, etc.)
- Support HCs to provide in-service CME training, for example, by informing peer review groups. Expand the model of peer review groups in all HCs in order to upgrade the in-service CME training capacities and boost primary care professionals' confidence. Encourage and support the creation and operation of mixed peer review groups (doctors and nurses) to provide a further impetus to teamwork and attain more satisfactory results for service users.
- Introduce continuing education norms for PHC managers. The Ministry of Health and Social Protection will develop a combined continuing education system for administrative physicians and managers of Primary Health Care Facilities (but not only), aiming at enhancing the management capacity of the health center management teams.
- Mechanisms to generate sustainable funding opportunities for CME training will be elaborated (e.g. lining CME to secondary revenues)
- A minimum number of Health Centers will be promoted in each region for the provision of CME training in each region until the network of University Medical Centers of Family Medicine becomes fully operational. These centers will be periodically supported by clinical experts, who possess the expertise needed for continuing education of family doctors and nurses, on priority topics of primary care and community health.
- Deliver regular training for family doctors on medical emergencies in cooperation with the National Center for Medical Emergency and the new University Center of Family Medicine.

EXPECTED RESULTS

- Sustainable and planned Continuing Education programs
- New skills for PHC doctors and nurses
- 50% of centers involved in structured and evidence-based activities of peer review groups
- A minimum of 2 HCs will be providing CME training in each region by 2025.

2.2.4. Specific objective 4 of policy 2

Expanding and redefining the role of nurses within the PHC professional teams

Interventions/actions:

- Review the job descriptions in terms of services provided by nurses at the primary health care level. Nurses will be trained to take on new roles, provide new services and proactively engage at the community level (e.g. management and provision of family care services, prevention of NCDs, etc.). The reviewed job descriptions of nurses will be tested in certain geographic regions that have the potential for success and will then extend throughout the country.
- Review nurses' job descriptions to include new responsibilities; empower them to have a higher professional profile, including the case of nurses working in health posts in remote areas where no family doctors are working.

EXPECTED RESULTS

- Nurses will have more skills and opportunities to act
- Nurses will be more engaged in the multidisciplinary teams (e.g. social workers, psychologists, etc.)
- Nurses work in communities will be more proactive.

2.2.5. Specific objective 5 of policy 2

Creating a stimulating and motivating environment for professional and responsible teamwork in PHC

Interventions/actions:

- Reassess, reformat, and improve PHC professionals' job descriptions (for both family doctors and nurses). Define the appropriate professional skills for various PHC positions and strengthen the nurses' role to perform multiple tasks, with the aim of facilitating the work of physicians and keeping the community cost of services under control. Support teamwork and interdisciplinary work at health centers (delegation of team tasks, mixed groups of doctors and nurses, management teams: physicians, financiers, nurses, etc.)
- Set up a working environment where stressful factors in the professional routine are avoided or reduced through good management practices, and effective human resources policies. Raise managers' and workers' awareness of the causes and effects of stress. Engage with the staff to build constructive and effective relationships.
- Set up rules in the institution that help maintain proper work-time balance and provide protection from arbitrariness.
- Care for the workers' well-being and health through effective health promotion programs and initiatives to reduce personal and peer stress. Develop an open and supportive culture for professionals experiencing stress or other forms of mental health abuse
- Provide incentives to motivate the staff working in remote and disadvantaged areas. The Ministry of Health and Social Protection will develop a series of policies that will support the equitable distribution of staff and their retention in vulnerable communities across different catchment areas.

EXPECTED RESULTS

- PHC professionals will feel supported to provide more quality services
- Increased self-esteem and motivation of PHC professionals.

Strategic change:

Increasingly trained PHC professionals work in a motivating environment to deliver the best health services at the grassroots level

Output Indicator for policy 2:

- 50% of the physicians working at the PHC will be family medicine physicians;
- 50 family nurses operating at the PHC will have completed the new Family and Community Nursing Master's Program;
- At least one excellence health center set up and included in the training programs.

2.3. Policy 3: Health infrastructure and technology in PHC facilities

Context and issues to address

In addition to qualified and dedicated human resources, PHC system services depend on an adequate infrastructure (including adequate space for services, power and water supply, etc.), information and communication technology (including internet access and computerized data management), and health technologies (including drugs, vaccines, medical devices and other consumables).

It is necessary to review the minimum standards and more investment is needed to improve the health centers infrastructure in order for them to correspond to the functional standards of a PHC modern approach in terms of accessibility (especially for people with disabilities), room for advisory services, teamwork, triage room, appropriate reception and waiting rooms. Reconstruction or rehabilitation of all the old HCs and relevant health posts will continue gradually, prioritizing the older ones and those covering large populations.

Problems related to patients' access to laboratory and diagnostic services are particularly observed in rural areas. For simple tests, recommended by general practitioners, patients should go to polyclinics in urban areas. There is a pattern of collecting blood samples in PHC centers or health posts and transporting them to centralized laboratories (check-up program), but it covers only healthy individuals who take preventive tests. This strategy foresees ways to optimize existing laboratory capacity by coordinating the work between several health centers and transporting samples from the point of care to a central laboratory. The Check-up Program has improved access to screening tests and related technology at health centers, including digital technology for ECGs. But there is still a significant lack of diagnostic equipment in some PHC centers, as well as a lack of standardization of the medical equipment used by any health center; each has different equipment. Most GPs lack basic equipment such as thermometers, nebulizers, otoscopes, ophthalmoscopes, spirometers, diapasons, sight screen tables, etc. There is no imaging technology in PHC and ECG is provided only under the Check-up Program. Basic equipment for nurses is not standardized and is missing in many health centers.

In 2016, the SDC project Health for All provided PHC physicians and nurses in two regions with a set of standardized medical equipment. In this context, the adaptation of standards for medical equipment and their gradual fulfillment will be considered, taking into account the functional capacity of the different levels of PHC centers (urban, rural, HC, health posts with a GPs and without GPs) and use of international experiences and standards. In general, health centers and posts are well-equipped for immunization and the cold chain, while refrigerated temperatures are maintained at appropriate levels.

Overall objective III. Enabling access to a PHC with adequate and sustainable infrastructure and diagnostic technology

2.3.1. Specific objective 1 of policy 3

Sustainably strengthening the construction infrastructure of HCs

Interventions/actions

- Draft and approve norms on the construction infrastructure of PHC facilities with the aim of ensuring universal health coverage and equal access to services.
- Rehabilitate health centers according to the above norms, through public investment and donor support. MoHSP will continue to implement the rehabilitation program of 300 health centers
- Monitor and gradually resolve problems related to the accessibility of persons with disabilities to PHC facilities and eventually meet the requirements of the relevant legislation.
- Clarify the roles and responsibilities of LGUs in developing/maintaining PHC construction infrastructure. Funding and co-funding mechanisms will be designed and implemented to strengthen local government capacities for the maintenance

and rehabilitation of health infrastructure. Local government authorities will ultimately resolve the legal aspects of ownership of primary care centers, paving the way for further investment in these centers by the local government and its potential partners, including the private sector.

EXPECTED RESULTS

- More than 75% of the population (including people with disabilities) will have access to rehabilitated HCs by 2025.
- In 50% of municipalities, LGUs will be involved in the HCs maintenance.

2.3.2. Specific objective 2 of policy 3

Increasing access to diagnostic and treatment services at the PHC level as per a revised basic package

Interventions/actions

- Draft and approve norms of the diagnostic equipment and tools in PHC facilities, for both physicians and nurses
- Gradually meet standards regarding diagnostic equipment;
- Strengthen selected health centers in 10 major cities with the purpose to create a focused model of providing family medicine, diagnostic services (RO, imaging), laboratory and rehabilitation services. This model will then be scaled up in other urban areas;
- Introduce flexible alternatives through logistical support for the collection of the biological samples at the rural HCs and their centralized analysis. This model will be applied in rural HCs, which find it difficult or impossible to provide laboratory service;
- Draft and approve the list of rapid laboratory diagnostic tests, performed in PHC facilities and regulate the service provision (in each HC or in a centralized mode)
- Use Telemedicine equipment/services in remotely isolated areas/areas with reduced staff/nurses and with no family doctors
- Expand the existing model or enable the use of the check-up equipment for other diagnostic activities at the health center.

EXPECTED RESULTS

- Services will be provided closer to patients.
- 75% of cases can be managed at the PHC level. Patients will have more trust PHC services.
- Services will be more cost-effective, unnecessary travel/over-referral to secondary care will be reduced.
- Strategic change: PHC infrastructure is upgraded in a harmonized manner throughout the country enabling equal access to all to PHC services.

Output Indicator for policy 3

- 1,500 physicians are equipped with a modern diagnostic equipment package;
- More than 75% of the population (including persons with disabilities) will have access to rehabilitated HCs that provide full diagnostic services;
- Increase the PHC-managed disease cases by 10% of cases and decrease by 5% of cases hospitalized for certain diseases.

2.4 Policy 4: PHC information system

Context and issues to address

PHC information system is a good tool that helps decision-making at two levels: PHC service management and public health protection.

PHC information system challenges in Albania are similar with other countries'; there may be lack of data or poor validity in certain areas, or low/fragmented use of data analysis. Currently, most HC data is required by and reported to the Compulsory Health Insurance Fund. Some data are required by the local health care units. Rarely do PHC providers receive feedback on the relevant outcomes of the shared information, and rarely do they use the information to assess the community needs or to plan. The strategy foresees the reconception of the object, template and reporting pathways for most of the existing information systems (the establishment of Health Care Operators and the transformation of the Regional Health Directorates into Local Health Care Units is an opportunity to reform the information system at the PHC). New Public Health Institutions will make better use of the epidemiological data generated in PHC centers to monitor at-risk populations.

Overall objective IV: Establishing and implementing the PHC-focused Health Management Information System

Interventions/actions

- Assess the current Health Management Information System (HMIS) status and adapt it to the new institutional framework taking into account e-health developments; assess the rationality and effectiveness of reporting forms
- Agree on the data to be collected/reporting format and reporting time (to avoid unnecessary information, duplication, overload)
- Train HC staff, local care units, and the operator to perform their roles within the HMIS. Guide decision-makers on the use of information in order to develop more appropriate/evidence-based health policies
- Standardize, streamline the information flow and improve data on chronic diseases in PHC facilities. Strengthen the role of LHCUs
- Continuously improve the e-prescription and referral system and plan the development of a patient e-record at the PHC level

EXPECTED RESULTS

- An agreed set of data collection templates.
- Trained Professionals at the Operators/Local Care Units/Health Centers in using HMIS. Informed decision-makers about the implementation of information obtained from real-time data analysis.
- Better tailored evidence-based policies of PHC supported by the HMIS.

Strategic change:

Better use of information produced by HMIS in PHC to continually improve service performance and improve health outcomes

Output Indicator for policy 4

100% of the HCs report based on a new and effective format, on the data to be collected at the PHC (avoiding unnecessary information, duplications, and overload) and 100% receive feedback on the analysis results.

2.5. Policy 5: Basic PHC Services for Universal Health Coverage

Context and issues to address

Recent Albanian health system policies emphasize the need for universal health coverage, the provision of quality and equitable health services to the entire population. Finally, these policies have been reflected in the implementation of the National Check-up Program and in the lifting of co-payments for visits to health services, thereby improving access to PHC services.

The basic service package is the key instrument that provides the necessary range of services at the PHC level for the entire population. There are seven categories of services included in the existing package: from emergency care to health promotion and education. The package does not specify services provided at health posts or health points. All health centers are committed to providing integrated services in the package although they have variable capacities, skills staff, and access to laboratory tests. The revision of the basic service package will reflect new developments and models of services, as well as new skills acquired by health staff. It will adapt them to the health needs and capacities of different PHC levels. The revision process should ensure that everyone benefits from PHC services equally.

PHC can achieve its long-term goal of improving community health by ensuring inclusion and cooperation with citizens. Effective activation of individuals is achieved in 4 steps: getting the individuals/families closer to primary health care services; positive feedback during the meeting with PHC services; interaction; joint decision-making on care and treatment.

Overall objective V: Increasing access to basic PHC services for all and including individuals, families and communities to optimize their health.

2.5.1. Specific objective 1 of policy 5

Improving and adjusting the basic health care package in accordance to needs, while simultaneously increasing the clinical autonomy in PHC

Interventions/actions

- Evaluate/review the current basic package delivery at the PHC level. The basic services within the package will be reviewed according to their effectiveness, cost, scientific ground, and current patterns of disease burden.
- Review the current functioning of the services, with the aim of assigning more clinical autonomy to PHC practitioners when making decisions about the treatment of common chronic illnesses.
- Add new services and integrate them with psychosocial services (palliative care, family care, psychological care, physical rehabilitation, etc. (physiotherapy is part of physical rehabilitation)
- Strengthen the continuity of care delivery for NCDs. The Ministry of Health and Social Protection will supplement the system of patient follow-up with counter-referral rules from specialists to family doctors, in order to rationalize patient care.

EXPECTED RESULTS

- Increased rate of services provided for NCDs (proportional to current disease burden pattern)
- Increased number of cases properly treated in the health center and not referred to the specialist.
- Primary health care will solve 75% of patient and consumer health problems
- A fewer number of hospitalizations.

Strategic change: Increased range of evidence-based services included in the basic service package reflecting the main health needs of vulnerable groups

2.5.2. Specific objective 2 of policy 5

Ensuring sustainable cooperation between individuals, families and communities and PHC facilities.

Interventions/activities

Activating individuals

- Scale up access of individuals who are indifferent to primary health care by intensifying the existing screening/check-up programs, school activities, information campaigns, partnerships with community-based organizations, and specific interventions for certain groups or strata of the population.
- Give individuals the chance to ask questions, ask for information and explanations by establishing sufficient time standards of visits and special commitment of nurses; by supporting the appropriate qualification of physicians/nurses/psychologists/ social workers in communication; and setting up a confidential environment.
- Make joint decisions in the health and social care plan by applying effective instruments (questionnaires, checklists, protocols, individual care records, etc.), and by stimulating brainstorms over health problems, optional solutions, more appropriate alternatives, actions to be taken (by whom, when, how),
- Encourage and support the participation of individuals with chronic health problems in support groups by problem/issue. Clusters can be offline and/or online.
- Assign the care coordinator and promote him/her to individuals and families.
- Activating families
- Encourage to register with the same PHC unit (Health Center)
- Scale up home visits by the care team. Assess social, environmental, etc. vulnerabilities. Co-design family support plans with families. Involve social workers.
- Involve family members, under the individuals' informed consent in individual-specific care plans.
- Provide health education to family members in terms of care, monitoring of individuals with specific health problems.
- Activating communities

Assess the community environment (physical environment, social environment, etc.) in cooperation with Local Public Health Units.

- Stratify the community by health needs (community-level census).
- Communicate/inform on problems, solutions, necessary actions.
- Encourage the community to participate in civil organization (associations, organizations, groups, etc.).
- Involve the most prominent representatives or individuals in the consultative/decision-making bodies at the HC level, Regional Health Care Operator, Municipality.

Output Indicator for policy 5

- Increase by 10% of the managed disease cases at the PHC level, and decrease by

5% of cases certain diseases requiring hospitalization.
- 75% of health centers have appointed a community care coordinator

2.6. Policy 6: Financing and Contracting for Universal Health Coverage

Context and issues to address

Financing universal health coverage is a major instrument of protecting vulnerable groups from catastrophic costs in the event of illnesses. The Government of Albania has taken important steps in this regard (as described above in this document). Providing efficient allocation for basic levels of care such as PHC or Long-Term Care (social medical services of family care) results in reduced avoidance of hospitalization and consequently greater efficiency of health care funds.

In addition to ensuring an adequate funding of PHC services and family care, the way funding is provided or contracted to providers also influences providers' behavior. Passive access is typical of providers whose budget is allocated without any information about their performance. The implementation of more active funding means linking the transfer of funds, at least partially, with information about the providers' performance or the health needs of the population they serve. In Albania, it is necessary to gradually apply a risk-based payment system in parallel with the improvement of the information system after piloting the revised indicators in selected regions. These new reimbursement strategies are considered an incentive to change the providers' attitude by rewarding the best and hard-working GPs.

The contracting model will enable general practitioners or family doctors to practice new skills acquired through qualification/ specialization. They will also be allowed to perform increasingly complex services within the contract, reducing unnecessary hospitalization or visits at the specialist.

Although the list of reimbursable drugs has gradually expanded in recent years, drug expenditure still accounts for the most out-of-pocket direct health care expenditure in Albania. It is necessary to proceed with measures to ensure financial protection for all citizens.

Overall objective VI: Ensuring Universal Health Coverage in PHC

2.6.1. Specific objective 1 of policy 6

Ensuring adequate and sustainable financing of PHC

Interventions/activities

- Gradually introduce PHC service budgeting based on health needs, disease burden priorities, service package and available resources
- Budget integrated medical-social care services at the family level. To this end, it is necessary for the Compulsory Health Care Insurance Fund to work up close with the relevant Directorates of the health centers as well as with the Regional Operators, so that the budgets can respond to the citizens' needs.
- Improve the budgeting methodology and develop a training program on the practical application of this methodology. Train decision-makers (NO/OR & CHCIF) on primary care budgeting methods.
- Switch from historical budgets to investment planning in line with needs assessment.
- Switch from the current PHC payment model to a different model based on a combination of payment per capita and performance-based bonus. Evaluate the system's preparedness to apply performance-based bonuses gradually. Eventually adjust the HC staff salaries by increasing the flexibility in line with their workload and performance.
- Pilot community-based integrated funding of health and social services (e.g. home care).
- Ensure the use of 3% of secondary income for training HC staff, in particular to facilitate the implementation of mixed peer review groups as well as staff participation in the re-training bridge program for GPs.

- Allocate a dedicated budget within the PHC budget for preventive and health promotion activities.
- Identify additional funding sources for PHC outside the health sector, particularly through the local government and private sector contributions.

EXPECTED RESULTS

- Increased funds allocated to PHC 18% to 25%.
- Increased budget share allocated to Home Care Services: 0.5% in the second year, 1% in the third year 1, 5% in the fourth year, 2% in the fifth year of the implementation of the strategy.
- Decreased personal expenditure of vulnerable groups.

2.6.2. Specific objective 2 of policy 6

Coordinating the service contracting with the improved quality/performance of PHC services

Interventions/activities

- Adopt the service package according to the needs and capacities of PHC facilities/ the customized package to each PHC level (University Centers for Family Medicine, Health Centers, Health posts)
- Train NO/ROs, HCs managers to understand the contracting mechanisms
- Adapt contracting to allow family doctors to perform a broader range of procedures in their daily practice and to use their skills autonomously.

EXPECTED RESULTS

- Performance indicators will be selected based on the health priorities.
- PHC contracts will turn into flexible tools to achieve better health outcomes.

2.6.3. Specific objective 3 of policy 6

Strengthening financial protection for all residents in the Republic of Albania

Performance indicators and expected results

- Protect against the impact of co-payments through:
- Application of fixed and non-percentage payments;
- Progressive exclusion and ceilings on the level of co-payments by low-income families
- Application of regulatory mechanisms to enable doctors to prescribe appropriate, quality and inexpensive drugs
- The gradual inclusion of consumables in the reimbursement scheme.
- Protect against indirect payments through:
- Support for/recognition of informal caregivers in the family and review of criteria and assessment of the need for caregivers for people with disabilities.
- Performance of tests without moving the patient; relieve transportation charges (dialysis, chemo/radiotherapy, disability etc).
- Elimination of possible shortages of drugs, equipment, and medical supplies
- Contracting non-public providers to cover missing services in types or geographical distribution.
- Increase transparency in healthcare through:
- Establishment of the National Patient Board.
- Utilizing e-Albania platforms, "The Albania we want" portal, and the co-governance portal.

- Strengthening the roles of the Ombudsman, State Audit Institute and High Inspectorate of Declaration and Audit of Assets and Conflict of Interest (HIDACCI).

EXPECTED RESULTS

- 100% of fix and not rate-based co-payment.
- Include at least 1 medical device (outpatient care) each year in the reimbursement scheme.
- Relieve 50% of the transportation costs for patients on dialysis, chemotherapy/radiotherapy.

Strategic change:

- PHC funding is sustainable and gradually performance-based; it improves the motivation of family doctors to provide more quality services.
- Family-based medical-social services start being budgeted.

Indicator results for policy 6

- The percentage of funds allocated to the PHC increases from 18% to 25% of the total health budget;
- Percentage of budget allocated for Home Care Services 2% in the fifth year of strategy implementation.

2.7 Policy 7: Defining and piloting new types of services and geographic redistribution

Context and issues to address

A series of factors are causing changes in the tendency and distribution of the Albanian population health needs. The proportion of the elderly is increasing and there is a need thereof for PHC services to address non-communicable diseases, mental health problems and disabilities more systematically. Currently in Albania, hypertension and diabetes are the most commonly treated diseases at PHC level. Unless long-term care for chronic patients (with their complex presentations and co-morbidities) is properly coordinated, there will be a high risk of hospitalization. While traditional maternal and child health care services are well organized and provided, PHC in Albania will begin to provide new and well integrated services in these areas.

Furthermore, the PHC should adapt to the specific needs of vulnerable populations (the isolated elderly, the disabled, the Roma community, etc.). They are quite exposed to health risks and fall under the categories least protected from these risks' negative consequences. Currently, PHC services for vulnerable groups are separate from social services. Both services need to be more coordinated and integrated.

Adolescents are a target group with specific health needs, including substance abuse, depression, sexual health and nutrition, but PHC utilization rates are very low, impacted by low expectations and lack of appropriate services. New models of integrated services for adolescents (e.g. HEADSS) should also be integrated into the Albanian PHC.

The geographical distribution of the population has changed significantly in Albania while the territorial organization of the PHC has not changed much in the last 30 years. Health centers and outpatient centers are unevenly distributed throughout the country, with large cities having health centers that cover a population ten times larger than those in rural areas. In Tirana or other major cities, the health centers' capacity is bigger in terms of medical staff and some special services, such as: child and woman counseling centers. Territorial redistribution of health centers is needed and in order to establish new comprehensive and integrated models of family medicine and social support services, a new level of health care center will be piloted in areas with greater needs and appropriate capacities: family medicine centers.

Overall objective VII: Adapting PHC services to the population needs based on the demographic, epidemiological and social analysis.

2.7.1. Specific objective 1 of policy 7

Organizing PHC service integrated with social care at local level

Interventions/activities

- Pilot a new model of integrated organization of social and health services for vulnerable groups in 4 cities (one for each regional health operator), upon the establishment of a Social Health Center close to the Family Medicine Center with additional psychologists, social workers etc. This model will bring citizens services such as: Long-term care, home care, palliative care, community mental health care, psychological, social and legal counseling, as well as self-care and nutrition, rehabilitation services, parenting services and improving the NCDs community management.
- Ensure the local government active commitment in providing social and health support to communities (ensure the best possible links between PHC and local communities); Involve municipal representatives in the annual PHC regional meetings and discuss specific cases where needs and strategies for problem solving have not been met.
- Establish a Health and Social Protection Board at the regional level to coordinate the social and health sectors with the Operators and Municipalities
- Reorganize social home care services, palliative care, community mental health care, NCDs prevention in order to provide health and social care to families/ communities. Pilot day care services provided by social workers integrated with medical services provided by nurses.
- Prepare a systematic information exchange platform between municipalities and PHC facilities about the number, location and social and health needs of vulnerable groups and individuals.
- Replicate successful models of co-financing services designated by municipalities (for example palliative care in Korca).

EXPECTED RESULTS

- By 2025, at least 12 Health and Social Protection Boards will be operational and they will propose actions to improve the integration of health and social care at their community level.
- Four models of integrated care will be piloted (e.g. long-term care, home care services, mental health services, palliative care services, social and psychological care, disease prevention at the community level), lessons learned will be identified and included in policy decisions; relevant changes will be made to the legal framework to enable the integrated service delivery.

Strategic change: Individuals in communities benefit from integrated services such as: long-term care, social and psychological care, home care, palliative care, mental health, NCDs control at community level.

2.7.2. Specific objective 2 of policy 7

Supporting the vertical integration of PHC services

Performance indicators and expected results

- Improve PHC coordination with links of the health and social care system;
- Ensure continuity of care and reduce barriers to referral and counter referral to/ from specialists.

- Assign designated nurses (random nurses) who will follow up/support the patient throughout the system
- Improve the e-referral system that enables counter-referral
- Draft and implement new clinical guidelines and protocols that define clinical referral criteria and not merely the administrative ones set by the Compulsory Health Care Insurance Fund. This will be made possible through collaboration between all system stakeholders, such as Family Doctors' Associations, the Faculty of Medicine and the Faculty of Technical Medical Sciences, the Order of Physicians, the Compulsory Health Care Insurance Fund, the Ministry of Health and Social Protection and its agencies.

EXPECTED RESULTS

- Better patient follow-up/better continuity of care.
- More aware/accountable specialist on patient follow-up.

2.7.3. Specific objective 3 of policy 7

Improving PHC services by prioritizing vulnerable and high-risk groups

Interventions/actions

- Ensure support of HCs by LHCU and HCSOs to assess the risk level and vulnerability in the population they cover (the elderly, women, children, patients with chronic diseases, ethnic groups, etc.), in order to continuously adapt services to needs;
- Train health care providers in specific needs, communication and case management in marginalized groups.
- Develop and promote models of successful cooperation between regional Operator agencies, Local Government and health center teams and the Non-Governmental Organizations, aiming at supporting vulnerable groups within communities as well as empowering these groups; so that they can take over the solution of their health problems.

- Target groups to consider:

a) The elderly (piloting geriatric care, family care, creating an integrated model of medical-social care, etc.)
b) Patients with chronic illnesses - evaluation/ monitoring of patients with multiple morbidity/stratification of the covered population
c) People with disabilities - more social than health care services
d) The Roma community - they need integration/ very poor/problems with education/often have problems with access to services/ often their drugs are not reimbursed
e) Care for children with special needs including Autism, Down syndrome, etc.
f) Adolescent health
g) Evaluation, updating and implementation of protocols (protocols adopted in 2016)

EXPECTED RESULTS

- PHC staff will have the skills and knowledge to handle groups difficult to cover.
- Addressed vulnerable groups will properly benefit from PHC services.

2.7.4. Specific objective 4 of policy 7

Remodeling the geographical distribution of PHC in order to provide more efficient care, while ensuring access to PHC services for all categories of the covered population and reorganizing HCs at different levels.

Performance indicators and expected results

- Territorial mapping of the HC distribution for each Operator
- Draft and enforce field distribution norms by the population covered and the burden of diseases or health problems for each PHC facility, including health centers, health posts and new family medicine centers. Review the organization and their linking at each level.
- Flexible adaptation of health service resources/delivery based on the population characteristics and needs.
- Establish a model of the Family Medicine Center, pilot and integrate it into the PHC system. Family Medicine Centers will be established based on existing health care centers, serving a significant population (e.g. 30,000 to 40,000 residents) and having a high number of health staff. In a second phase, this model will serve to transform some peripheral hospitals into PHC facilities. Family Medicine Centers may include some special services (mental, palliative, physiotherapy, integrated social psychological care, etc.)
- Pilot the university model in some selected family medicine centers, in collaboration with the Ministry of Education and Sport, and establish the University Center of Family Medicine.
- Pilot a network of HC/social care communities in remote areas; Establish models of coordination and collaboration between small health centers in rural areas, with the aim of expanding the range of services (including 24 hour service, or laboratory testing services) and providing a suitable professional environment that will subsequently provide continuous quality improvement.

EXPECTED RESULTS

- Different models of PHC organization will be defined to better and clearly reflect the needs of the covered population;
- The Model of Family Medicine Center will be established by providing more quality services and improving the PHC image
- More flexibility within the legal definitions of different models of PHC organization
- Reduced inconsistencies among HCs. Comprehensive family health centers will provide more quality services.

Strategic change: Greater flexibility in service organization enables better access to iproved PHC service standards

Indicator results for policy 7

- 10 Family Medicine centers established;
- 4 pilot centers of integrated health and social care;
- 10 24-hour service models in remote areas provided through coordinated rural HCs;
- 2 new palliative care centers at the PHC.

2.8. Policy 8: PHC service quality

Context and issues to address

In order for PHC services to not only be universally accessible but also more qualitative, they must be evidence-based, safe and people-centered.

Over the last 15 years, there has been some progress in improving the PHC quality in Albania, with the introduction of institutional mechanisms, such as: the establishment of the National Center for Quality, Safety and Accreditation (NCQSA), the adoption of the legal regulatory framework for the accreditation of health institutions, as well as the development of some clinical guidelines.

However, there are many gaps regarding:

- Clinical protocols that are either not utilized or outdated. PHC professionals are not fully involved in the process, and training is rarely organized to support the guidelines or protocols implementation. In such circumstances, clinical audits, as a mode of continuous quality improvement, have not been performed. Updated and comprehensive clinical protocols and guidelines are needed. They will be evidence-based, best international experience-based and customized to the Albanian PHC setting. The clinical audit model will follow the process of applying protocols in the clinical practice.
- In 2018, the accreditation process started at PHC health centers. The HAP 1 program contributed to the advancement of this process by defining the templates and by enhancing the HC capacity to complete the accreditation required forms.

Overall objective VIII: Improving PHC service quality

2.8.1. Specific objective 1 of policy 8

Providing quality PHC service (basic quality benchmarks and further quality improvement)

Performance indicators and expected results

- Develop a pattern of continuous quality and governance improvement at PHC level
- Clearly define the roles of institutions (NCQSA, NO/RO, IPH, UHC, MHSP, associations, professional orders) in protocol drafting, implementing and monitoring
- Develop the prerequisites for the quality cycle implementation
- Develop, review, and improve clinical guidelines and protocols on key public health priorities through teamwork and collaboration with field specialists and decision-makers
- Adaptation and approval of PHC clinical protocols for more frequent/more serious health problems, involvement of the Ministry in the process, (the Operator, the quality center, IPH, etc.) PHC service providers, the University, the associations of professionals. Using international best practices and reflecting local capacity and organization.
- Tailoring protocol clinical topics to CME processes to ensure that more training activities cover new topics.
- Development of missing protocols;
- Development of evidence-based prevention guidelines for each age group. Regular updates;
- Develop peer review methodologies, clinical audit and supportive supervision.
- Build capacities for the implementation and monitoring of protocols through peer-reviews and clinical audits

EXPECTED RESULTS

- Improved or newly developed guidelines, clinical protocols
- Field specialists in working groups
- Methodologies for peer-reviews and clinical audit will be defined. The quality cycle will be defined and implemented
- The pattern of professional development will be strengthened (no sanctions that harm the process).

2.8.2. Specific objective 2 of policy 8

Supporting the accreditation procedures implementation in all HCs

Interventions/activities

- Clarify the situations of Health Posts in the accreditation process
- Establish teams at the HC level in charge of the accreditation process
- Train HC staff in completing the accreditation process and forms
- Set up a HC board under the accreditation process requirements that will regularly perform clinical checks, using peer-reviews.
- Accredit social services - new service standards adopted or revised
- Accredit the newly established services (e.g. integrated family-social care, palliative services, etc.), and new technologies (e.g. micro lab, telemedicine, etc.)

2.8.3. Specific objective 3 of policy 8

Including patients and consumers in the quality improvement mechanisms

Performance indicators and expected results

- Develop a platform/app focusing on PHC to receive complaints and involve consumers in the quality improvement mechanism.

Expected results/objectives

- 100% of HCs will be involved in the accreditation process
- 75% of HCs meet at least the red standards
- 50% of HCs meet optimal standards
- 25% of HCs meet future standards

Strategic change: Communities benefit from higher quality and evidence-based services provided by accredited HCs.

Indicator results for policy 8

- 100% of HCs are engaged in the accreditation process;
- At least 75% of HCs meet red standards,
- 50% of HCs achieve optimal standards,
- 25% of HCs meet future standards.

2.9. Policy 9: Management of PHC facilities

Context and issues to address

PHC Health Centers in Albania are health institutions responsible for the management of staff, budget, infrastructure, outputs and information systems. Health centers have always been a short of managerial capacities. Health center managers, as well as other staff such as head nurses, should continually improve their skills in team management, information management, continuous quality improvement, and community health assessment. Reforming the health care system and introducing new institutions, such as the Health Service Operator, will build other cross-institutional relationships and will create other management tasks for health centers. HC managers will need to support Public Health Units and Operators for needs assessment, strategic planning and budgeting for new services in their catchment areas.

In particular, there is a need for better managerial skills and capacities at larger health centers. Approaches such as manager-customized trainings and the introduction of more efficient models in health centers will serve to continuously improve PHC management.

Overall objective IX: Improving the management efficiency of PHC facilities

Performance indicators and expected results

- Enhance other managerial capacities and team work in health centers (managers/ nurses/economists). This will be achieved by recruiting graduate students in the Master of Health Management, particularly in the management of new health centers and combined health and social services, as well as in the implementation of continuing education programs for health institution managers.
- Enhance the HC staff capacity to support regional operators in defining strategic health plans (needs assessment at community level, planning the necessary services, capacity building to implement new services, etc.)
- Prepare strategic planning models and pilot them in selected HCs in cooperation with the HC staff. This process was piloted in the regions of Fier and Dibra. The process of developing and implementing strategic and operational plans for each Primary Care Center will extend to most primary care structures over the next five years.
- Enable best practice sharing among Health Centers: replication of experiences in organizing meetings between health centers and community representatives in order to establish open and transparent communication between health and social service teams and residents in the catchment areas so that: a) health centers respond directly to the community demands and needs; and b) residents can better understand the provided services and the opportunities and limitations of primary health care.
- Extend the experience of providing continuing education to healthcare professionals, including managers, using re-certification and crediting topics related to health institution management.
- Facilitate the establishment, piloting and management of HC networks
- Standardize the necessary administrative documentation (packages and document templates available to health center management teams in electronic and hard copy formats).

EXPECTED RESULTS

- Improved performance of the operational management of the health center;
- Improved capacity for needs assessment and proposal for the establishment of new services necessary at the community level.

Strategic change: HC management becomes a proactive management function by better meeting the communities' health needs

Indicator results for policy 9

- At least 50% of health centers have prepared strategic plans and annually exchange the best management experiences.

3. Monitoring and accountability

The Ministry of Health and Social Protection is charged with the implementation of this Strategy according to the action plan pursuant to the policy goals and the achievement of objectives as well as its subordinate institutions, University of Medicine, Order of Nurses, Midwives, Physiotherapists of Albania, Order of Physicians of Albania as well as local government units.

The PHC action plan monitoring will be led by the thematic group for social inclusion, within the integrated policy management group (IPMG) approved by Prime Minister Order no. 157, dated 22.10.2018 "On taking measures for the implementation of the broad sectorial / intersectorial approach, as well as the establishment and the functioning of the integrated sectorial/ intersectorial mechanism".

The Statistical Indicators and Integrity Group (SIIG) will coordinate the monitoring activity with the General Directorate of Health and Social Protection Policy and Development in the Ministry of Health and Social Protection.

The whole process will be carried out with the participation of representatives from the institutions responsible for this political document implementation. Representatives of: INSTAT, academic circles and university centers, civil society can also participate in the consultation tables.

The two-year monitoring reports will be prepared by the General Directorate of Health and Social Protection Policy and Development and will be approved by the IPMG.

Monitoring will be based on following detailed indicators for each specific objective and analyzing progress and problems in each of the priority policies. The standardized report will contain standardized facts and data, based on the indicators frame provided by this national plan.

In support of the action plan monitoring implementation, in relation to the impact indicators will be the quantitative results provided by hospital information systems as well as healthy longevity assessments, provided in the indicators passport.
The national action plan monitoring reports preparation process will be harmonized with the United Nations Economic Commission for Europe (UNECE) national report preparation, on progress regarding the International Action Plan on Aging implementation of Madrid and the Regional Implementation Strategy (MIPAA / RIS).

4. References

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Primary health care in Albania: Structures and Model of Care. Comprehensive PHC assessment. WHO European Center for Primary Health Care. WHO Regional Office for Europe. Nov. 2018.

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Law no. 10107, dated 30.03.2009, On health care.

Law no. 10138, dated 11.05.2009 On public health.

Decision of Council of Ministers No. 419, dated 4.7.2018, On the Establishment, Organization and Functioning of the Health Care Services Operator".

Decision of Council of Ministers No. 737, dated 05.11.2014, On the financing of PHC services from the compulsory health insurance scheme".

Decision of Council of Ministers no. 101 dated 4.2.2015. Health Services Package, in the public PHC funded by the Compulsory Health Care Insurance Fund.

Law no. 8652, dated 31.7.2000, On organization and functioning of the local government" (as amended by law no. 9208, dated 18.3.2004).

National Health Strategy 2016-2020,

National NCD control plan 2016-2020,

Health Promotion Action Plan 2017-2021.

National Strategy for Development and Integration, 2015-2020

5. Annex: Action plan

Action plan based on strategic document
(Phc services plan 2020-2025)
I. Strategic goal.
II. Policy goal 1()
III. Budget program 1 contributing towards the policy goal
(Insert MTBP program name contributing towards policy goal achievement) (Take into consideration that a Policy Goal may be implemented through more than one budget program)
In the case of the PwD Policy Document, examine whether the Policy Goal is financed via one or several Budget Programs.

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No.		Outcome Reference with budget program outputs	Responsible institutions		Implementation time frame		Indicative costs (in thousand ALL) (these costs are total costs, calculated based on the IPSIS cost formats)	Financing source		Financial gap
					Start Date	End Date		State Budget	Foreign Financing	
TOTAL							5,981,494	5,014,094	454,600	512,800
I.	**Policy Goal 1 (Policy Goal 1 (Improving the institutional capacity for better governance of PHC through the inclusion of all influential institutions))**									
	Policy Goal 1 TOTAL						**802,778**	**802,778**	**-**	**-**
A.	**SPECIFIC OBJECTIVE 1. A. Building the organizational capacities of the Ministry of Health and Social Protection and the Health Service Operator at the central, regional and local level regarding the strategic planning and performance monitoring of PHC**	(Filling in this cell concerns only the results, not the objective)	MHSP; HCSOs	MHSP; HCSOs; Donors; Other institutions	1st trimester, 2020	4th trimester, 2021	49,253	49,253	-	-
B	**SPECIFIC OBJECTIVE 2. Strengthening, improving and expanding the capacities of the Public Health institutions network**		MHSP; HC; PHI	HCSO; LHCUs; PHI; HC	4th trimester, 2020	4th trimester, 2025	592,965	592,965	-	-
C	**SPECIFIC OBJECTIVE 3. Strengthening the local government units' (LGUs) support role towards PHC**		MHSP; LGUs	HCSOs; HC; LGUs	4th trimester, 2020	4th trimester, 2025	160,560	160,560	-	-

No.		Outcome Reference with budget program outputs	Responsible institutions		Implementation time frame		Indicative costs (in thousand ALL) (these costs are total costs, calculated based on the IPSIS cost formats)	Financing source		Financial gap
					Start Date	End Date		State Budget	Foreign Financing	
II.	**Policy Goal 2: (Supporting the development of sustainable and quality human resources as regards PHC)**									
	Policy Goal 2 TOTAL						**194,515**	**119,515**	**3,000**	**72,000**
A.	**SPECIFIC OBJECTIVE 1. A. Supporting general practitioners in becoming family physicians**	MHSP; UoM	MHSP, Order of Physicians; Other partner institutions	4th trimester, 2020	4th trimester, 2025	41,095	9,095	-	32,000
B	**SPECIFIC OBJECTIVE 2. Improving basic education programs for PHC professionals**	MHSP; UoM	MHSP, Order of Physicians; Other partner institutions	4th trimester, 2021	4th trimester, 2025	93,035	50,035	3,000	40,000
C	**SPECIFIC OBJECTIVE 3. Improving the role of continuing education in order to support critical developments of PHC services provision**	HCSOs; NMEC	MHSP, FMEC; HCSOs, Order of Physicians, Order of Nurses, other partners	1st trimester, 2021	4th trimester, 2025	33,100	33,100	-	-
D	**SPECIFIC OBJECTIVE 4. Expanding and redefining the role of nurses within the PHC professional team**	MHSP	HCSOs, HC, Order of Nurses	4th trimester, 2020	4th trimester, 2022				
E	**SPECIFIC OBJECTIVE 3. Improving the role of continuing education in order to support critical developments of PHC services provision**	MHSP; HCSOs	MHSP; HCSOs; HC	4th trimester, 2020	4th trimester, 2021				
III.	**Policy Goal 3: (Enabling access to a PHC with adequate and sustainable infrastructure and diagnostic technology)**									
	Policy Goal 3 TOTAL						1,787,695	1,164,095	423,600	200,000
A.	**SPECIFIC OBJECTIVE 1. Sustainably strengthening the construction infrastructure of HCs.**	MHSP	HCSOs, LGUs, Other/ partner institutions	1st trimester, 2020	4th trimester, 2025	1,429,500	1,000,500	399,000	30,000
B	**SPECIFIC OBJECTIVE 2. Increasing access to diagnostic and treatment services at the PHC level as per a revised basic package**	MHSP	HCSOs, LGUs, Other/ partner institutions	1st trimester, 2020	4th trimester, 2025	358,195	163,595	24,600	170,000
IV.	**Policy Goal 4: (Establishing and implementing the PHC-focused Health Management Information System)**									
	Policy Goal 4 TOTAL						63,000	54,000	9,000	-

No.		Outcome Reference with budget program outputs	Responsible institutions		Implementation time frame		Indicative costs (in thousand ALL) (these costs are total costs, calculated based on the IPSIS cost formats)	Financing source		Financial gap
					Start Date	End Date		State Budget	Foreign Financing	
A.	**SPECIFIC OBJECTIVE 1. Establishing and implementing the PHC-focused Health Management Information System**		MHSP	HCSOs, CHCIF, LGUs, PHI, HCs	4th trimester, 2020	4th trimester, 2023	63,000	54,000	9,000	-
V.	**Policy Goal 5: (Increasing access to basic PHC services for all and including individuals, families and communities to optimize their health)**									
	Policy Goal 5 TOTAL						18,190	18,190	-	-
A.	**SPECIFIC OBJECTIVE 1. Improving and adjusting the basic health care package in accordance to needs, while simultaneously increasing the clinical autonomy in PHC**		MHSP	HCSOs, CHCIF, LGUs, HCs	4th trimester, 2020	4th trimester, 2022	18,190	18,190	-	-
VI.	**Policy Goal 6: (Ensuring Universal Health Coverage in PHC through sustainable and efficient budgeting)**									
	Policy Goal 6 TOTAL						1,304,853	1,294,853	10,000	-
A.	**SPECIFIC OBJECTIVE 1. Ensuring adequate and sustainable financing of PHC**		MHSP	CHCIF, HCSOs, HCs	1st trimester, 2022	4th trimester, 2025	1,304,853	1,294,853	10,000	-
VII.	**Policy Goal 7: (Adapting PHC services to the population needs based on the demographic, epidemiological and social analysis)**									
	Policy Goal 7 TOTAL						1,593,978	1,353,178	-	240,800
A.	**SPECIFIC OBJECTIVE 1. Organizing PHC services towards increased integration with the social care at local level**		MHSP; HCSOs	CHCIF, HCSOs, LGUs, LHCUs, HCs, other partners	4th trimester, 2020	4th trimester, 2025	185,738	185,738	-	-
B	**SPECIFIC OBJECTIVE 2. Supporting the vertical integration of PHC services**		MHSP,	HCSOs, HCs	1st trimester, 2021	4th trimester, 2021	-	-	-	-
C	**SPECIFIC OBJECTIVE 3. Increasing community coverage of PHC services by prioritizing vulnerable and high-risk groups**		HCSOs	LHCUs, HCs, PHI, UoM, other partners	4th trimester, 2020	4th trimester, 2025	44,000	44,000	-	-
D	**SPECIFIC OBJECTIVE 4. Remodeling the geographical distribution of PHC in order to provide more efficient care, while ensuring access to PHC services for all categories of the covered population and reorganizing HCs at different levels**		MHSP	HCSOs, PHI, HCs, CHCIF, HCSOs, UoM	4th trimester, 2020	4th trimester, 2025	1,364,240	1,123,440	-	240,800

No.		Outcome Reference with budget program outputs	Responsible institutions	Implementation time frame		Indicative costs (in thousand ALL) (these costs are total costs, calculated based on the IPSIS cost formats)	Financing source		Financial gap
				Start Date	End Date		State Budget	Foreign Financing	
VIII.	**Policy Goal 8: (Applying a continuous quality improvement model for PHC services)**								
	Policy Goal 8 TOTAL					117,200	117,200	-	-
A.	**SPECIFIC OBJECTIVE 1. Ensuring the provision of increasingly better PHC services by guaranteeing the basic quality norms and applying continuous quality improvement models**	MHSP	Quality Center, UoM, CHCIF, HCSOs, HCs, PHI, Order of Physicians, Association of Professionals, other partners	4th trimester, 2020	4th trimester, 2025	91,200	91,200	-	-
B	**SPECIFIC OBJECTIVE 2. Supporting the accreditation procedures implementation in all health centers**	**MHSP**	**Quality Center, UoM, CHCIF, HCSOs, HCs, PHI, Order of Physicians, Association of Professionals, other partners**	**1st trimester, 2021**	**4th trimester, 2025**	**26,000**	**26,000**	**-**	**-**
IX.	**Policy Goal 9: (Improving the management efficiency of PHC institutions)**								
	Policy Goal 9 TOTAL					99,285	90,285	9,000	-
A.	**SPECIFIC OBJECTIVE 1. Ensuring the provision of increasingly better PHC services by guaranteeing the basic quality norms and applying continuous quality improvement models**	**MHSP**	**Quality Center, UoM, CHCIF, HCSOs, HCs, PHI, Order of Physicians, Association of Professionals, other partners**	**4th trimester, 2020**	**4th trimester, 2025**	**97,285**	**88,285**	**9,000**	**-**

Annual implementation cost for policies 1-9

YEAR 2020				YEAR 2021				YEAR 2022				YEAR 2023				YEAR 2024				YEAR 2025			
Indicative costs (in thousand ALL) (these costs are total costs, calculated based on the IPSIS cost	Financing source		Financial gap	Indicative costs (in thousand ALL) (these costs are total costs, calculated based on the IPSIS cost	Financing source		Financial gap	Indicative costs (in thousand ALL) (these costs are total costs, calculated based on the IPSIS cost	Financing source		Financial gap	Indicative costs (in thousand ALL) (these costs are total costs, calculated based on the IPSIS cost	Financing source		Financial gap	Indicative costs (in thousand ALL) (these costs are total costs, calculated based on the IPSIS cost	Financing source		Financial gap	Indicative costs (in thousand ALL) (these costs are total costs, calculated based on the IPSIS cost	Financing source		Financial gap
	State gap budget	Foreign Financ-ing			State gap budget	Foreign Financ-ing			State gap budget	Foreign Financ-ing			State gap budget	Foreign Financ-ing			State gap budget	Foreign Financ-ing			State gap budget	Foreign Financ-ing	
853,619	**705,119**	**93,500**	**55,000**	**843,579**	**532,279**	**184,100**	**127,200**	**1,187,928**	**943,528**	**158,000**	**86,400**	**1,013,068**	**923,868**	**7,800**	**81,400**	**1,050,323**	**941,123**	**7,800**	**101,400**	**1,032,976**	**968,176**	**3,400**	**61,400**
151,694	**151,694**	**-**	**-**	**136,004**	**136,004**	**-**	**-**	**119,770**	**119,770**	**-**	**-**	**125,770**	**125,770**	**-**	**-**	**131,770**	**131,770**	**-**	**-**	**137,770**	**137,770**	**-**	**-**
39,377	39,377	-	-	9,877	9,877	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
100,558	100,558	-	-	108,368	108,368	-	-	96,010	96,010	-	-	96,010	96,010	-	-	96,010	96,010	-	-	96,010	-	-	-
29,500	5,760	6,000	-	17,760	17,760	-	-	23,760	23,760	-	-	29,760	29,760	-	-	35,760	35,760	-	-	41,760	-	-	-
4,548	**4,548**	**-**	**-**	**41,258**	**34,858**	**-**	**6,400**	**38,523**	**29,123**	**3,000**	**6,400**	**26,428**	**20,028**	**-**	**6,400**	**41,880**	**15,480**	**-**	**26,400**	**41,880**	**15,480**	**-**	**26,400**
4,548	4,548	-	-	10,948	4,548	-	6,400	6,400	-	-	6,400	6,400	-	-	6,400	6,400	-	-	6,400	6,400	-	-	6,400
-	-	-	-	5,500	5,500	-	-	16,408	13,408	3,000	-	13,408	13,408	-	-	28,860	8,860	-	20,000	28,860	8,860	-	20,000
-	-	-	-	6,620	6,620	-	-	6,620	6,620	-	-	6,620	6,620	-	-	6,620	6,620	-	-	6,620	6,620	-	-
-	-	-	-	9,095	9,095	-	-	9,095	9,095	-	-	-	-	-	-	-	-	-	-	-	-	-	-
-	-	-	-	9,095	9,095	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
559,195	**455,195**	**89,000**	**15,000**	**406,600**	**187,000**	**179,600**	**40,000**	**406,100**	**211,100**	**155,000**	**40,000**	**137,100**	**102,100**	**-**	**35,000**	**138,600**	**103,600**	**-**	**35,000**	**140,100**	**105,100**	**-**	**35,000**
514,000	420,000	89,000	5,000	344,000	184,000	155,000	5,000	342,000	182,000	155,000	5,000	76,500	71,500	-	5,000	76,500	71,500	-	5,000	76,500	71,500	-	5,000
45,195	35,195	-	10,000	62,600	3,000	24,600	35,000	64,100	29,100	-	35,000	60,600	30,600	-	30,000	62,100	32,100	-	30,000	63,600	33,600	-	30,000
				0	0	0	0																
4,500	**-**	**4,500**	**-**	**22,500**	**18,000**	**4,500**	**-**	**18,000**	**18,000**	**-**	**-**	**18,000**	**18,000**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
4,500	-	4,500	-	22,500	18,000	4,500	-	18,000	18,000	-	-	18,000	18,000	-	-	-	-	-	-	-	-	-	-
4,548	**4,548**	**-**	**-**	**9,095**	**9,095**	**-**	**-**	**4,548**	**4,548**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
4,548	4,548	-	-	9,095	9,095	-	-	4,548	4,548	-	-	-	-	-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	323,713	323,713	-	-	327,013	323,713	3,300	-	327,013	323,713	3,300	-	327,113	323,713	3,400	-
-	-	-	-	-	-	-	-	323,713	323,713	-	-	327,013	323,713	3,300	-	327,013	323,713	3,300	-	327,113	323,713	3,400	-
106,640	**66,640**	**-**	**40,000**	**170,783**	**89,983**	**-**	**80,800**	**238,125**	**198,125**	**-**	**40,000**	**340,508**	**300,508**	**-**	**40,000**	**372,810**	**332,810**	**-**	**40,000**	**365,113**	**365,113**	**-**	**-**
7,200	7,200	-	-	11,903	11,903	-	-	23,805	23,805	-	-	35,708	35,708	-	-	47,610	47,610	-	-	59,513	59,513	-	-
-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
4,000	4,000	-	-	8,000	8,000	-	-	8,000	8,000	-	-	8,000	8,000	-	-	8,000	8,000	-	-	8,000	8,000	-	-
95,440	55,440	-	40,000	150,880	70,080	-	80,800	206,320	166,320	-	40,000	296,800	256,800	-	40,000	317,200	277,200	-	40,000	297,600	297,600	-	-
11,400	**11,400**	**-**	**-**	**24,400**	**24,400**	**-**	**-**	**24,400**	**24,400**	**-**	**-**	**19,000**	**19,000**	**-**	**-**	**19,000**	**19,000**	**-**	**-**	**19,000**	**19,000**	**-**	**-**
11,400	11,400	-	-	19,200	19,200	-	-	19,200	19,200	-	-	13,800	13,800	-	-	13,800	13,800	-	-	13,800	13,800	-	-
-	-	-	-	5,200	5,200	-	-	5,200	5,200	-	-	5,200	5,200	-	-	5,200	5,200	-	-	5,200	5,200	-	-
11,095	**11,095**	**-**	**-**	**32,940**	**32,940**	**-**	**-**	**14,750**	**14,750**	**-**	**-**	**19,250**	**14,750**	**4,500**	**-**	**19,250**	**14,750**	**4,500**	**-**	**2,000**	**2,000**	**-**	**-**
11,095	11,095	-	-	32,940	32,940	-	-	14,750	14,750	-	-	19,250	14,750	4,500	-	19,250	14,750	4,500	-	2,000	2,000	-	-

Policy 1

Action plan based on strategic document
(PHC Services Plan 2020-2025)

I. Strategic goal: Increasing quality and expanding PHC services and improving access

II. Policy Goal 1 (Improving the institutional capacity for better governance of PHC through the inclusion of all influential institutions))

III. Budget program 1 contributing towards the policy goal

(Insert MTBP program name contributing towards policy goal achievement) (Take into consideration that a Policy Goal may be implemented through more than one budget program) In the case of the PwD Policy Document, examine whether the Policy Goal is financed via one or several Budget Programs.

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No.		Outcome Reference with budget program outputs	Details of activities	Responsible institutions		Implementation time frame		Indicative costs (in thousand ALL) (these costs are total costs, calculated based on the IPSIS cost formats)	Financing source		Financial gap
						Start Date	End Date		State Budget	Foreign Financing	
TOTAL								802,778	802,778	-	-
A.	**SPECIFIC OBJECTIVE 1. A. Building the organizational capacities of the Ministry of Health and Social Protection and the Health Service Operator at the central, regional and local level regarding the strategic planning and performance monitoring of PHC**	**(Filling in this cell concerns only the results, not the objective)**		**Insert the responsible institution (Lead)**	**Contributing institution (if any)**	**1st tri-mester, 2020**	**4th 3-mester, 2021**	**49,253**	**49,253**	-	-
A.1	The Health Care Service Operator (HCSO), in collaboration with MHSP, health centers (HC) and other actors, drafts regional and local health plans, as well as the performance monitoring indicative frameworks	Primary Health Care Services Code 07220	National and Regional Plans Drafting 10-person Working Group Drafting plans for local HCs with the involvement of 100 professionals 10-person Expert Working Group ALL 160,000 per month * 4 months + 100 professionals 1/3 of business days in a month for 4 months ALL 100000 per month/3 + 10000 for operating expenses	HCSOs	MHSP; Other insti-tutions	1st trimester, 2020	4th trimester, 2021	19,753	19,753	-	-

No.		Outcome Reference with budget program outputs	Details of activities	Responsible institutions		Implementation time frame		Indicative costs (in thousand ALL) (these costs are total costs, calculated based on the IPSIS cost formats)	Financing source		Financial gap
						Start Date	End Date		State Budget	Foreign Financing	
A.2	HCSOs rely on the provision of required infrastructure and staffing with human resources	Primary Health Care Services Code 07220	1. equipping 10 offices * ALL 500 000/office		2. recruiting 25 full-time specialists (ALL 80 000/ month) (ALL 500 000 for operating expenses)	MHSP	HCSOs, Donors	1st trimester, 2020	4th trimester, 2020	29,500	29,500
B	**SPECIFIC OBJECTIVE 2. Strengthening, improving and expanding the capacities of the Public Health institutions network**			**MHSP; HC; PHI**	**HCSO; LHCUs; PHI; HC**	**4th trimester, 2020**	**4th trimester, 2025**	**592,965**	**592,965**	-	-
B1	Assigning the institutional roles of HCs and local health care units (LHCUs) as regards public health	Planning Administration Management Code 01110 Output 1: Adopted legal and sub-legal acts	Cost of drafting a legal act from MTBP, which totals = ALL 9 095 000/ act: composed of [ALL 5 595 000 costs (salaries + soc. sec.) + ALL 3500 000 for operating expenses] Number of sub-legal acts	MHSP	HCSOs, LHCUs, PHI, other partners	4th trimester, 2020	4th trimester, 2021	9,095	-	-	-
B2	Tailoring information on the health status and disability for the population of each HC in order to allow for the assessment of health not solely based on demographic categories, but based on those social (e.g., the homeless/ unemployed), ethnic and cultural (e.g., Roma community) as well.	Primary Health Care Services Code 07220	Including 200 HCs (400 physicians and 800 nurses) in obtaining specific information about the relevant population of HCs (average salary of physicians and nurses, including soc. sec. = ALL 80 000/month (1 month of work + ALL 10000 for operating expenses)	AG	HCSOs; LHCUs; PHI;	1st trimester, 2022	4th trimester, 2025	576,060	384,040	-	-

No.		Outcome Reference with budget program outputs	Details of activities	Responsible institutions		Implementation time frame		Indicative costs (in thousand ALL) (these costs are total costs, calculated based on the IPSIS cost formats)	Financing source		Financial gap
						Start Date	End Date		State Budget	Foreign Financing	
B3	Standardizing the laboratory capacities of public health regarding the prevention and control of communicable diseases with epidemic potential and environmental risks.	Primary Health Care Services Code 07220	Analyzing the situation, drafting and approving a document on PH laboratory standards 10 specialists (6-month salary (average of ALL 130 000/month including soc. sec) + ALL 10000 for operating expenses	PHI	HCSOs, LHCUs, HCs	1st trimester, 2021	4th trimester, 2021	7,810	-	-	-
C	**SPECIFIC OBJECTIVE 3. Strengthening the local government units' (LGUs) support role towards PHC**			**MHSP; LGUs**	**HCSOs; HC; LGUs**	**4th trimester, 2020**	**4th trimester, 2025**	**160,560**	**160,560**	-	-
C1	Municipal support for HC maintenance in their territory, based on the existing legislation.	Primary Health Care Services Code 07220	60 HC are provided annual maintenance by LGUs. (Lump sum of ALL 100 000/each health center)	LGU	HCSOs, HCs	1st trimester, 2021	4th trimester, 2025	126,000	126,000	-	-
C2	Ensuring coordination between the Operator and LGU in order to coordinate social protection services provided at the municipal level with those provided at the health care center level	Primary Health Care Services Code 07220	Approved coordination structures within the existing organizations 2 people in 36 local units (average salary including soc. securities ALL 80 000/month)	MHSP	HCSOs, LGUs, HCs	4th trimester, 2020	4th trimester, 2025	34,560	34,560	-	-

Policy 2

ACTION PLAN BASED ON STRATEGIC DOCUMENT
(PHC Services Plan 2020-2025)
I. Strategic goal: Increasing quality and expanding PHC services and improving access
II. Policy Goal 2 (Supporting the development of sustainable and quality human resources as regards PHC)
III. Budget program 1 contributing towards the policy goal

(Insert MTBP program name contributing towards policy goal achievement) (Take into consideration that a Policy Goal may be implemented through more than one budget program) In the case of the PwD Policy Document, examine whether the Policy Goal is financed via one or several Budget Programs.

000/ALL

No.		Outcome Reference with budget program outputs	Details of activities	Responsible institutions		Implementation time frame		Indicative costs (in thousand ALL) (these costs are total costs, calculated based on the IPSIS cost formats)	Financing source		Financial gap
						Start Date	End Date		State Budget	Foreign Financing	
	TOTAL							194,515	119,515	3,000	72,000
A.	**SPECIFIC OBJECTIVE 1. A. Supporting general practitioners in becoming family physicians**	**(Filling in this cell concerns only the results, not the objective)**		**Insert the responsible institution (Lead)**	**Contrib-uting institution (if any)**	**4th trimester, 2020**	**4th trimester, 2025**	**41,095**	**9,095**	-	**32,000**
A.1	Establishing an accredited medium-term training program without leave from work for general practitioners under 45 years old, to be conducted in stages (bridge program in family medicine)	Primary Health Care Services Code 07220	Drafting and implementing a training program of several months with the involvement of (10 experts * ALL 50 000/month * 6 months + ALL 200 000 for administrative expenses * 2 courses/year)	MHSP, University of Medicine (UoM)	MHSP, UoM, other/ partner institutions	4th trimester, 2022	4th trimester, 2025	32,000	-	-	32,000
A.2	Applying policies to encourage newly graduates to become family physicians	Planning Administration Management Code 01110 Output 1: Adopted legal and sub-legal acts	Cost of drafting a legal act from MTBP, which totals = ALL 9 095 000/ act: composed of [ALL 5 595 000 costs (salaries + soc. sec.) + ALL 3500 000 for operating expenses] Number of sub-legal acts 1 act	MHSP	MHSP, Order of Physicians	4th trimester, 2020	4th trimester, 2021	9,095	9,095	-	-

No.		Outcome Reference with budget program outputs	Details of activities	Responsible institutions		Implementation time frame		Indicative costs (in thousand ALL) (these costs are total costs, calculated based on the IPSIS cost formats)	Financing source		Financial gap
						Start Date	End Date		State Budget	Foreign Financing	
B	**SPECIFIC OBJECTIVE 2. Improving basic education programs for PHC professionals**					**4th trimester, 2021**	**4th trimester, 2025**	**93,035**	**50,035**	**3,000**	**40,000**
B1	Supporting 2 Family Medicine Excellence Centers, expanding university education in Family Medicine at the excellence HC level in addition to that at the university hospital	Planning Administration Management Code 01110 Output 1: Adopted legal and sub-legal acts: Primary Health Care Services Code 07220 (Output 2 Supply and Installation of medical equipment and furnishing of health centers)	Cost of drafting a legal act from MTBP, which totals = ALL 9 095 000/ act: composed of [ALL 5 595 000 costs (salaries+ soc. sec.) + ALL 3500 000 for operating expenses]. Providing professional qualification and didactic training tools (lump sum investments (infrastructure + equipment) 20 000 000/ each center)	MHSP	UoM, QSUT, HCSOs, FMEC	1st trimester, 2022	4th trimester, 2025	49,095	9,095	-	40,000
B2	Developing a Master's Program for family and community nurses	Primary Health Care Services Code 07220	Drafting and implementing a 1-year program. With the involvement of 10 experts (part of monthly salaries 50% on average ALL 50 000/ month + ALL 1 000 000/ year for administrative expenses)	UoM	MHSP, Order of Nurses, HCSOs	4th trimester, 2021	4th trimester, 2024	27,500	27,500	-	-

No.		Outcome Reference with budget program outputs	Details of activities	Responsible institutions		Implementation time frame		Indicative costs (in thousand ALL) (these costs are total costs, calculated based on the IPSIS cost formats)	Financing source		Financial gap
						Start Date	End Date		State Budget	Foreign Financing	
B3	Establishing long-term post-university education programs for general practitioners and family physicians, by developing training modules for new skills (medical emergency, mother and child's consultation center, prenatal care, palliative care, health care, family-based care, case management, etc.)	Primary Health Care Services Code 07220	Drafting and implementing training modules of several months with the involvement of 10 local experts * 10 days * ALL 30000/day to develop module programs * 5 modules : trainings 12 total 15-day trainings (10 local experts * 50% of monthly salary = ALL 50 000/month on average) + ALL 30 000 for administrative expenses/training	UoM	MHSP, QSUT, HC-SOs, FMEC	4th trimester, 2022	4th trimester, 2025	16,440	13,440	3,000	-
C	**SPECIFIC OBJECTIVE 3. Improving the role of continuing education in order to support critical developments of PHC services provision**					**1st trimester, 2021**	**4th trimester, 2025**	**33,100**	**33,100**	**-**	**-**
C1	Supporting HCs to create CE opportunities in the workplace: 'peer groups' and 'mixed doctor-nurse peer groups'.	Primary Health Care Services Code 07220	Training, systematic meetings. 100 HCs develop CE models in the workplace (1 meeting * lump sum of ALL 30 000/training/ meeting) 2 meetings/per center/year in total	HCSOs	MHSP, Order of Physicians, Order of Nurses, other partners	1st trimester, 2021	4th trimester, 2025	30,000	30,000	-	-
C2	Conducting periodic training for family physicians regarding medical emergencies, in collaboration with the National Medical Emergency Center (NMEC) and Family Medicine Excellence Centers (FMEC)	Primary Health Care Services Code 07220	4 one-week training courses annually * 25 participants/course. (10 experts * average of 50% of average salary = ALL 50000/month + ALL 30 000 for operating expenses/course	NMEC	FMEC, MHSP, HCSOs	1st trimester, 2021	4th trimester, 2025	3,100	3,100	-	-

No.		Outcome Reference with budget program outputs	Details of activities	Responsible institutions		Implementation time frame		Indicative costs (in thousand ALL) (these costs are total costs, calculated based on the IPSIS cost formats)	Financing source		Financial gap
						Start Date	End Date		State Budget	Foreign Financing	
D	**SPECIFIC OBJECTIVE 4. Expand and redefine the role of nurses within the PHC professional team**					**4th trimester, 2020**	**4th trimester, 2022**	**18,190**	**18,190**	-	-
D1	Expanding nurses' tasks/roles, in order to provide new services and ensure proactive engagement at the community level (e.g, managers and providers of family-based care services, NCD prevention counseling, etc.)	Planning Administration Management Code 01110 Output 1: Adopted legal and sub-legal acts: Care services	Drafting and approving of legal act documents (2 legal acts) Cost of drafting a legal act from MTBP, which totals = ALL 9 095 000/act: composed of [ALL 5 595 000 costs (salaries+ soc. sec.) + ALL 3500 000 for operating expenses].	MHSP	HCSOs, HC, Order of Nurses	1st trimester, 2021	4th trimester, 2022	18,190	18,190	-	-
E	**SPECIFIC OBJECTIVE 3. Improving the role of continuing education in order to support critical developments of PHC services provision**					**4th trimester, 2020**	**4th trimester, 2021**	**9,095**	**9,095**	-	-
E1	Establishing rules in the institution to help maintain the proper balance during work and ensuring protection against arbitrariness. Looking after the welfare and health of employees through effective programs and initiative to reduce personal and peer stress	Primary Health Care Services Code 07220	Drafting regulations for institutions (no costs)	HCSOs	MHSP, HCs	1st trimester, 2021	4th trimester, 2021	-	-	-	-

No.		Outcome Reference with budget program outputs	Details of activities	Responsible institutions		Implementation time frame		Indicative costs (in thousand ALL) (these costs are total costs, calculated based on the IPSIS cost formats)	Financing source		Financial gap
						Start Date	End Date		State Budget	Foreign Financing	
E2	Utilizing incentives to motivate the staff working in remote and unfavorable areas Developing measures towards supporting the uniform distribution of staff and maintaining such staff in communities in need in various geographical areas	Planning Administration Management Code 01110 Output 1: Adopted legal and sub-legal acts: Care services	Drafting a legal act (for 2021) on updating incentives to motivate the staff in remote mountainous areas. Cost of drafting a legal act from MTBP, which totals = ALL 9 095 000/ act: composed of [ALL 5 595 000 costs (salaries+ soc. sec.) + ALL 3500 000 for operating expenses]. (the financial effects of the application will be calculated upon drafting of the legal act)	MHSP	HCSOs, HCs	1th trimester, 2021	4th trimester, 2021	9,095	9,095	-	-

Policy 3

ACTION PLAN BASED ON STRATEGIC DOCUMENT
(PHC Services Plan 2020-2025)
I. Strategic goal: Increasing quality and expanding PHC services and improving access
II. Policy Goal 2 (Supporting the development of sustainable and quality human resources as regards PHC)
III. Budget program 1 contributing towards the policy goal

(Insert MTBP program name contributing towards policy goal achievement) (Take into consideration that a Policy Goal may be implemented through more than one budget program) In the case of the PwD Policy Document, examine whether the Policy Goal is financed via one or several Budget Programs.

000/ALL

No.		Outcome Reference with budget program outputs	Details of activities	Responsible institutions		Implementation time frame		Indicative costs (in thousand ALL) (these costs are total costs, calculated based on the IPSIS cost formats)	Financing source		Financial gap
						Start Date	End Date		State Budget	Foreign Financing	
	TOTAL							1,787,695	1,164,095	423,600	200,000
A.	**SPECIFIC OBJECTIVE 1. Sustainably strengthening the construction infrastructure of HCs.**	**(Filling in this cell concerns only the results, not the objective)**		**Insert the responsible institution (Lead)**	**Contributing institution (if any)**	**1st trimester, 2020**	**4th trimester, 2025**	**1,429,500**	**1,000,500**	**399,000**	**30,000**
A.1	Rehabilitating HCs as per adopted standards, through public investments and donor support. Continuing the rehabilitation program for 300 health centers.	Primary Health Care Services Code 07220 (Output 1: Reconstructing health centers in cities/ administrative units)	Approving infrastructure standards. Rehabilitating 300 PHC units (lump sum obtained from the MTBP for the construction of HCs + including costs by donors, the Swiss Fund, The Red Crescent etc.), and of polyclinics	MHSP	HCSOs, LGUs, Other/ partner institutions	1st trimester, 2020	4th trimester, 2025	1,399,500	1,000,500	399,000	-
A.2	Monitoring and resolving issues concerning the accessibility of persons with disabilities to PHC institutions and gradually fulfilling conditions pursuant to the applicable legislation.	Primary Health Care Services Code 07220 (Output 1: Reconstructing health centers in cities/ administrative units)	Applying standards (e.g., regarding ramps for wheelchairs and Braille signs for persons with impaired vision) in 100 HCs (50 thousand for each HC)	MHSP	HCSOs, LGUs, Other/ partner institutions	1st trimester, 2020	4th trimester, 2025	30,000	-	-	30,000

No.		Outcome Reference with budget program outputs	Details of activities	Responsible institutions		Implementation time frame		Indicative costs (in thousand ALL) (these costs are total costs, calculated based on the IPSIS cost formats)	Financing source		Financial gap
						Start Date	End Date		State Budget	Foreign Financing	
B	**SPECIFIC OBJECTIVE 2. Increasing access to diagnostic and treatment services at the PHC level as per a revised basic package**					**1st trimester, 2020**	**4th trimester, 2025**	**358,195**	**163,595**	**24,600**	**170,000**
B1	Developing and approving norms regarding diagnostic equipment and tools (including the list of rapid tests) for PHC institutions for both physicians and nurses, and gradually implementing such norms	Planning Administration Management Code 01110 Output 1: Legal and sub-legal acts approved and Primary Health Care Services Code 07220 (output 2 Supply and Installation of medical equipment and furnishing of health centers)	Cost of drafting a legal act (or standard) from MTBP, which totals = ALL 9 095 000/act: composed of [ALL 5 595 000 costs (salaries+ soc. sec.) + ALL 3500 000 for operating expenses]. Procuring the equipment package for 900 doctors. Packages = ALL 60 000/doctor (from previous HAP program experience) + ALL 100 thousand expenses for various medical materials (equipping 150 doctors/year starting in 2020) + 2400 nurses x ALL 26 000/nurse (from previous HAP program experience); 600 nurses per year	MHSP	HCSOs, other/ partner institutions	1st trimester, 2020	4th trimester, 2025	188,195	163,595	24,600	-
B2	Strengthening health centers in 10 major cities for the purpose of creating a focused family medicine, diagnostic (RO, imaging), laboratory and rehabilitation services provision model. This model will then be gradually applied in other urban areas.	Primary Health Care Services Code 07220 (Output 2 Supply and Installation of medical equipment and furnishing of health centers)	Strengthening clinical laboratories in 10 HCs in major cities. (new devices + furnishing) through an approximate lump sum of ALL 15 000 000 per HC at the rate of 2 HCs/year.	MHSP	HCSOs, other/ partner institutions	1st trimester, 2021	4th trimester, 2025	150,000	-	-	150,000

No.		Outcome Reference with budget program outputs	Details of activities	Responsible institutions		Implementation time frame		Indicative costs (in thousand ALL) (these costs are total costs, calculated based on the IPSIS cost formats)	Financing source		Financial gap
						Start Date	End Date		State Budget	Foreign Financing	
B3	Introducing flexible alternatives through logistical support to collect biological samples at rural HCs and analyzing them in a centralized manner. This model will be applied in rural HCs, which find it difficult or impossible to provide laboratory services	Primary Health Care Services Code 07220	Reviewing the Feasibility Study on Introducing Laboratory Sample Transportation Model in 100 rural HCs as alternative methods (lump sum of ALL 10 000 000).	MHSP	HCSOs, other/ partner institutions	1st trimester, 2021	4th trimester, 2022	10,000	-	-	10,000
B4	Assessing the potential to expand the existing model or enabling the use of basic health check equipment for other activities concerning diagnosis at HCs.	Primary Health Care Services Code 07220	Feasibility Study, recommendation document Lump sum of ALL 10 000 000	MHSP	HCSOs	1st trimester, 2020	4th trimester, 2020	10,000	-	-	10,000

Policy 4

ACTION PLAN BASED ON STRATEGIC DOCUMENT
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III. Budget program 1 contributing towards the policy goal

(Insert MTBP program name contributing towards policy goal achievement) (Take into consideration that a Policy Goal may be implemented through more than one budget program) In the case of the PwD Policy Document, examine whether the Policy Goal is financed via one or several Budget Programs.

000/ALL

No.		Outcome Reference with budget program outputs	Details of activities	Responsible institutions		Implementation time frame		Indicative costs (in thousand ALL) (these costs are total costs, calculated based on the IPSIS cost formats)	Financing source		Financial gap
						Start Date	End Date		State Budget	Foreign Financing	
	TOTAL							**63,000**	**54,000**	**9,000**	**-**
A.	**SPECIFIC OBJECTIVE 1. Establishing and implementing the PHC-focused Health Management Information System**	**(Filling in this cell concerns only the results, not the objective)**		**Insert the responsible institution (Lead)**	**Contributing institution (if any)**	**4th trimester, 2020**	**4th trimester, 2023**	**63,000**	**54,000**	**9,000**	**-**
A.1	Coming to an agreement regarding the data to be collected/reporting format and reporting time (to avoid unnecessary information, duplications, overload)	Primary Health Care Services Code 07220	Reviewing and approving the information framework at PHC (study 10 local experts * 30 working days x ALL 30 000/day)	MHSP	HCSOs, CHCIF, LGUs, PHI, HCs	4th trimester, 2020	3rd trimester, 2021	9,000	-	9,000	-
A.2	Training the staff of HCs, LHCUs and HCSOs to perform their roles in HMIS. Instructing decision-makers on the use of information for the purpose of developing more adequate/fact-based health policies.	Primary Health Care Services Code 07220	Carrying out training meetings in 12 regions (36 meetings, ALL 500 thousand per meeting/ year)	MHSP	HCSOs, CH-CIF, LGUs, PHI, HCs	4th trimester, 2021	4th trimester, 2023	54,000	54,000	-	-

Policy 5

ACTION PLAN BASED ON STRATEGIC DOCUMENT
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III. Budget program 1 contributing towards the policy goal

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000/ALL

No.		Outcome Reference with budget program outputs	Details of activities	Responsible institutions		Implementation time frame		Indicative costs (in thousand ALL) (these costs are total costs, calculated based on the IPSIS cost formats)	Financing source		Financial gap
						Start Date	End Date		State Budget	Foreign Financing	
	TOTAL							**18,190**	**18,190**	**-**	**-**
A.	**SPECIFIC OBJECTIVE 1. Improving and adjusting the basic health care package in accordance to needs, while simultaneously increasing the clinical autonomy in PHC**	**(Filling in this cell concerns only the results, not the objective)**		**Insert the responsible institution (Lead)**	**Contributing institution (if any)**	**4th trimester, 2020**	**4th trimester, 2022**	**18,190**	**18,190**	**-**	**-**
A.1	Redefining services in the basic PHC service package. Adding new services and enabling integration with psychosocial services (palliative care, family-based care, psychological care, physical rehabilitation)	Primary Health Care Services Code 07220	Reviewing and approving the basic PHC services package: Indicative cost from MTBP, which totals = ALL 9 095 000/act composed of [ALL 5 595 000 costs (salaries+ soc. sec.) + ALL 3500 000 for operating expenses].	MHSP	HCSOs, CH-CIF, LGUs, HCs	4th trimester, 2020	4th trimester, 2021	9,095	9,095	-	-
A.2	Reviewing the current functioning of services, in order to grant more clinical autonomy to PHC doctors. Reinforcing the continued provision of care for NCDs in the patient follow-up system with the rules of reverse-referral by specialists to family physicians.	Primary Health Care Services Code 07220	Reviewing and adopting rules concerning referral and reverse-referral. Indicative cost from MTBP, which totals = ALL 9 095 000/act: composed of [ALL 5 595 000 costs (salaries+ soc. sec.) + ALL 3500 000 for operating expenses].	MHSP	HCSOs, CH-CIF, LGUs, HCs	4th trimester, 2021	4th trimester, 2022	9,095	9,095	-	-

Policy 6

ACTION PLAN BASED ON STRATEGIC DOCUMENT
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III. Budget program 1 contributing towards the policy goal

(Insert MTBP program name contributing towards policy goal achievement) (Take into consideration that a Policy Goal may be implemented through more than one budget program) In the case of the PwD Policy Document, examine whether the Policy Goal is financed via one or several Budget Programs.

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No.		Outcome Reference with budget program outputs	Details of activities	Responsible institutions		Implementation time frame		Indicative costs (in thousand ALL) (these costs are total costs, calculated based on the IPSIS cost formats)	Financing source		Finan-cial gap
						Start Date	End Date		State Budget	Foreign Financing	
	TOTAL							**1,304,853**	**1,294,853**	**10,000**	-
A.	**SPECIFIC OBJECTIVE 1. Ensuring adequate and sustainable financing of PHC**	**(Filling in this cell concerns only the results, not the objective)**		**Insert the responsible institution (Lead)**	**Contributing institution (if any)**	**1st trimester, 2022**	**4th trimester, 2025**	**1,304,853**	**1,294,853**	**10,000**	-
A.1	Budgeting integrated medical-social family-based care services.	Primary Health Care Services Code 07220: Output Number of visits at the primary care	Reviewing and adopting the annual budget as needed. May require a budget increase of up to 10% of the budget total for the output: Number of visits at the primary care, the average of three years from MTBP is ALL 3 237 232 000 (of which salaries + securities average = ALL 66 000 000 + expenses 602 = ALL 25 000 000 + internal transfers = ALL 3 146 132 000, such increase applying from 2022)	MHSP	CHCIF, HCSOs, HCs	1st trimester, 2022	4th trimester, 2025	1,294,853	1,294,853	-	-

No.		Outcome Reference with budget program outputs	Details of activities	Responsible institutions		Implementation time frame		Indicative costs (in thousand ALL) (these costs are total costs, calculated based on the IPSIS cost formats)	Financing source		Finan-cial gap
						Start Date	End Date		State Budget	Foreign Financing	
A.2	Switching from the current salary model of PHC to a different model based on a combination of per capita salary and the performance-based remuneration. Evaluating the system's readiness to gradually apply performance-based remuneration. Gradually adjusting the HC staff salaries by increasing flexibility in accordance with the workload and performance.	Primary Health Care Services Code 07220	Reviewing and approving the new salary model Generally, the highest performance will be compensated by the lowest, but a budget increase may be expected in some instances (Feasibility Study, recommendation document) Lump sum of ALL 10 000 000	MHSP	CHCIF, HCSOs, HCs	4th trimester, 2023	4th trimester, 2025	10,000	-	10,000	-

Policy 7

ACTION PLAN BASED ON STRATEGIC DOCUMENT
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II. Policy Goal 2 (Supporting the development of sustainable and quality human resources as regards PHC)
III. Budget program 1 contributing towards the policy goal

(Insert MTBP program name contributing towards policy goal achievement) (Take into consideration that a Policy Goal may be implemented through more than one budget program) In the case of the PwD Policy Document, examine whether the Policy Goal is financed via one or several Budget Programs.

000/ALL

No.		Outcome Reference with budget program outputs	Details of activities	Responsible institutions		Implementation time frame		Indicative costs (in thousand ALL) (these costs are total costs, calculated based on the IPSIS cost formats)	Financing source		Financial gap
						Start Date	End Date		State Budget	Foreign Financing	
TOTAL								**1,593,978**	**1,353,178**	**-**	**240,800**
A.	**SPECIFIC OBJECTIVE 1. Organizing PHC services towards increased integration with the social care at local level**	**(Filling in this cell concerns only the results, not the objective)**		**Insert the responsible institution (Lead)**	**Contributing institution (if any)**	**4th trimester, 2020**	**4th trimester, 2025**	**185,738**	**185,738**	**-**	**-**
A.1	Piloting a new organization model of integrated social and health services for groups in need in 4 cities (one for each regional health operator).	Primary Health Care Services Code 07220	Establishing a Social Health Center at the Family Medicine Center with the addition of psychologists, social workers etc. (Category IVa Salary specialists = ALL 81690/month * 2 specialists * 4 centers in 4 pilot cities)	MHSP	CHCIF, HCSOs, HCs	1st trimester, 2021	4th trimester, 2025	117,634	117,634	-	-
A.2	Establishing a Health and Social Protection Council at the regional level to coordinate the social and health sectors and Operators and Municipalities	Primary Health Care Services Code 07220	Coordination organism based on existing institutions: The salary of 5 high-level employees of Category IIa = ALL 160 000/month * 3 meetings per year * 3 preparatory work days per meeting	MHSP	HCSOs, LGUs, LHCUs, HCs	1st trimester, 2020	4th trimester, 2020	7,200	7,200	-	-

No.		Outcome Reference with budget program outputs	Details of activities	Responsible institutions		Implementation time frame		Indicative costs (in thousand ALL) (these costs are total costs, calculated based on the IPSIS cost formats)	Financing source		Financial gap
						Start Date	End Date		State Budget	Foreign Financing	
A.3	Replicating successful models of co-funding by the municipality for specific services (in accordance with the palliative care example in Korça)	Primary Health Care Services Code 07220	Day Special Services Center staffed with doctors and nurses (one center per year): average salary for 1 doctor = ALL 85000/ month + 2 nurses ALL 65000/month + 1 psychologist/social worker specialist of Cat. IVa = ALL 81690/ month + ALL 500 000 for miscellaneous expenses	HCSOs	CHCIF, HCSOs, LGUs, LHCUs, HCs, other partners	4th trimester, 2021	4th trimester, 2025	22,000			
B.	**SPECIFIC OBJECTIVE 2.** Supporting the vertical integration of PHC services	(Filling in this cell concerns only the results, not the objective)		Insert the responsible institution (Lead)	Contributing institution (if any)	1st trimester, 2021	4th trimester, 2021	-	-	-	-
B.1	Engaging nurses (random nurses) assigned to follow/support the patient throughout the system stages	Primary Health Care Services Code 07220	Redefining position in existing resources, reviewing tasks (no costs)	MHSP,	HCSOs, HCs	1st trimester, 2021	4th trimester, 2021	-	-	-	-
C.	**SPECIFIC OBJECTIVE 3. Increasing community coverage of PHC services by prioritizing vulnerable and high-risk groups**	**(Filling in this cell concerns only the results, not the objective)**		**Insert the responsible institution (Lead)**	**Contributing institution (if any)**	**4th trimester, 2020**	**4th trimester, 2025**	**44,000**	**44,000**	-	-
C.1	Ensuring support of HCs by LHCUs and HCSOs for risk and vulnerability assessment in the population they cover (the elderly, women, children, patients with chronic diseases, ethnic groups, etc.), for the continuous adjustment of services to needs.	Primary Health Care Services Code 07220	Preparing instruments, staff training and engagement using existing resources (Trainings: 40 trainings/ year * ALL 100000/ training (lump sum)	HCSOs	LHCUs, HCs	1st trimester, 2021	4th trimester, 2025	20,000	20,000	-	-

No.		Outcome Reference with budget program outputs	Details of activities	Responsible institutions		Implementation time frame		Indicative costs (in thousand ALL) (these costs are total costs, calculated based on the IPSIS cost formats)	Financing source		Financial gap
						Start Date	End Date		State Budget	Foreign Financing	
C.2	Training the health care staff on specific needs, communication and case management in vulnerable or marginalized groups.	Primary Health Care Services Code 07220	Preparing instruments, Trainings: 40 trainings/ year * ALL 100000/train-ing (lump sum)	HCSOs	PHI, UoM, HCs, other partners	4th trimester, 2020	4th trimester, 2025	24,000	24,000	-	-
D.	**SPECIFIC OBJECTIVE 4. Remodeling the geographical distribution of PHC in order to provide more efficient care, while ensuring access to PHC services for all categories of the covered population and reorganizing HCs at various levels**	**(Filling in this cell concerns only the results, not the objective)**		**Insert the responsible institution (Lead)**	**Contributing institution (if any)**	**4th trimester, 2020**	**4th trimester, 2025**	**1,364,240**	**1,123,440**	**-**	**240,800**
D.1	Defining the territorial HC distribution map for each regional HCSO, based on the approval and implementation of norms concerning site distribution by covered population and the disease burden or health problems of the geographical area. For each NES institution (including HCs, ambulatory clinic and new family medicine centers). Reviewing the organization and the relations at each level	Primary Health Care Services Code 07220	Approving norms, reorganizing the staff and responsibilities in at least 10% of existing HCs and ambulatory clinic (approximately 40 HCs and 100 ambulatory clinic). It will be necessary to increase staff by 10% with doctors and redistribute nursing staff. : (adding approximately 120 doctors for 6 years * ALL 85 000/month (average)	MHSP	HCSOs, PHI, HCs	4th trimester, 2020	1st trimester, 2021	130,000			
D.2	Piloting a Family Medicine Center model. Based on 10 HCs covering a significant population (e.g., 30.000 and 40.000 inhabitants) and with a large staff. Two of said HCs will become Excellence Centers to include post-university training.	Primary Health Care Services Code 07220	Approving new standards and services. Providing laboratory/ diagnostic equipment and infrastructure (lump sum of ALL 20 000 000/health center).	MHSP	CHCIF, HCSOs, HCs, UoM	4th trimester, 2020	4th trimester, 2025	200,000	-	-	200,000

No.		Outcome Reference with budget program outputs	Details of activities	Responsible institutions		Implementation time frame		Indicative costs (in thousand ALL) (these costs are total costs, calculated based on the IPSIS cost formats)	Financing source		Financial gap
						Start Date	End Date		State Budget	Foreign Financing	
D.2	Ensuring 24-hour service in rural and remote areas by piloting a coordination model in several rural HCs.	Primary Health Care Services Code 07220	Reorganizing existing resources (Human resources: Doctors with an average salary of ALL 85 000/month + 1 nurse with an average salary (including soc. securities) of ALL 60 000/month), for 120 rural centers.	MHSP	CHCIF, HCSOs, HCs	4th trimester, 2020	4th trimester, 2025	735,840	735,840	-	-

Policy 8

ACTION PLAN BASED ON STRATEGIC DOCUMENT
(PHC Services Plan 2020-2025)
I. Strategic goal: Increasing quality and expanding PHC services and improving access
II. Policy Goal 2 (Supporting the development of sustainable and quality human resources as regards PHC)
III. Budget program 1 contributing towards the policy goal

(Insert MTBP program name contributing towards policy goal achievement) (Take into consideration that a Policy Goal may be implemented through more than one budget program) In the case of the PwD Policy Document, examine whether the Policy Goal is financed via one or several Budget Programs.

000/ALL

No.		Outcome Reference with budget program outputs	Details of activities	Responsible institutions		Implementation time frame		Indicative costs (in thousand ALL) (these costs are total costs, calculated based on the IPSIS cost formats)	Financing source		Financial gap
						Start Date	End Date		State Budget	Foreign Financing	
	TOTAL							**117,200**	**117,200**	**-**	**-**
A.	**SPECIFIC OBJECTIVE 1. Ensuring the provision of increasingly better PHC services by guaranteeing the basic quality norms and applying continuous quality improvement models**	**(Filling in this cell concerns only the results, not the objective)**		**Insert the responsible institution (Lead)**	**Contributing institution (if any)**	**4th trimester, 2020**	**4th trimester, 2025**	**91,200**	**91,200**	**-**	**-**
A.1	Drafting, reviewing, updating clinical guidelines and protocols concerning the key priorities of public health, through team work and in collaboration with specialists in the field and decision-makers.	Primary Health Care Services Code 07220	Working groups involving approximately 30 professionals * ALL 90 000/month * 6 months	MHSP	Quality Center, UoM, CHCIF, HCSOs, HCs, PHI, Order of Physicians, Association of Professionals, other partners	4th trimester, 2020	4th trimester, 2022	16,200	16,200	-	-

No.		Outcome Reference with budget program outputs	Details of activities	Responsible institutions		Implementation time frame		Indicative costs (in thousand ALL) (these costs are total costs, calculated based on the IPSIS cost formats)	Financing source		Financial gap
						Start Date	End Date		State Budget	Foreign Financing	
A.2	Supporting protocol implementation through training. Relating the clinical protocol topics with the CME processes to ensure greater coverage of new topics during training activities.	Primary Health Care Services Code 07220	Short-term training courses: 20 courses. Each course's cost: Lump sum of ALL 300 000/course (including lecture experts + per diem + other administrative expenses) with 20-25 participants. Organization of short-term CME courses.	MHSP	Continuing Education Center, UoM, HCSOs, HCs, PHI, Order of Physicians, Association of Professionals, other partners	1st trimester, 2020	4th trimester, 2025	36,000	36,000	-	-
A.3	Developing methodologies for peer review, clinical audit and supportive supervision. Building capacities and providing support for protocol implementation and monitoring through clinical audit.	Primary Health Care Services Code 07220	Preparing instruments. Assigning responsibilities. Continuing implementation of clinical audit. 5 teams involving 30 professionals * ALL 130 000 monthly salary * 2 months per year	MHSP	Quality Center, UoM, CHCIF, HCSOs, HCs, PHI, Order of Physicians, Association of Professionals, other partners	4th trimester, 2021	4th trimester, 2025	39,000	39,000	-	-
B.	**SPECIFIC OBJECTIVE 2. Supporting the accreditation procedures implementation in all health centers**	**(Filling in this cell concerns only the results, not the objective)**		**Insert the responsible institution (Lead)**	**Contributing institution (if any)**	**1st trimester, 2021**	**4th trimester, 2025**	**26,000**	**26,000**	-	-
B.1	Including ambulatory clinics in the accreditation process Accrediting social services (adopting or reviewing standards). Accrediting newly-established services and new technologies	Primary Health Care Services Code 07220	Preparing instruments. Assigning responsibilities. Continuing implementation of clinical audit. 2 teams involving 10 professionals * ALL 130 000 monthly salary * 2 months per year	MHSP,	Quality Center, UoM, CHCIF, HCSOs, HCs, PHI, Order of Physicians, Association of Professionals, other partners	1st trimester, 2021	4th trimester, 2025	26,000	26,000	-	-

Policy 9

ACTION PLAN BASED ON STRATEGIC DOCUMENT
(PHC Services Plan 2020-2025)
I. Strategic goal: Increasing quality and expanding PHC services and improving access
II. Policy Goal 2 (Supporting the development of sustainable and quality human resources as regards PHC)
III. Budget program 1 contributing towards the policy goal

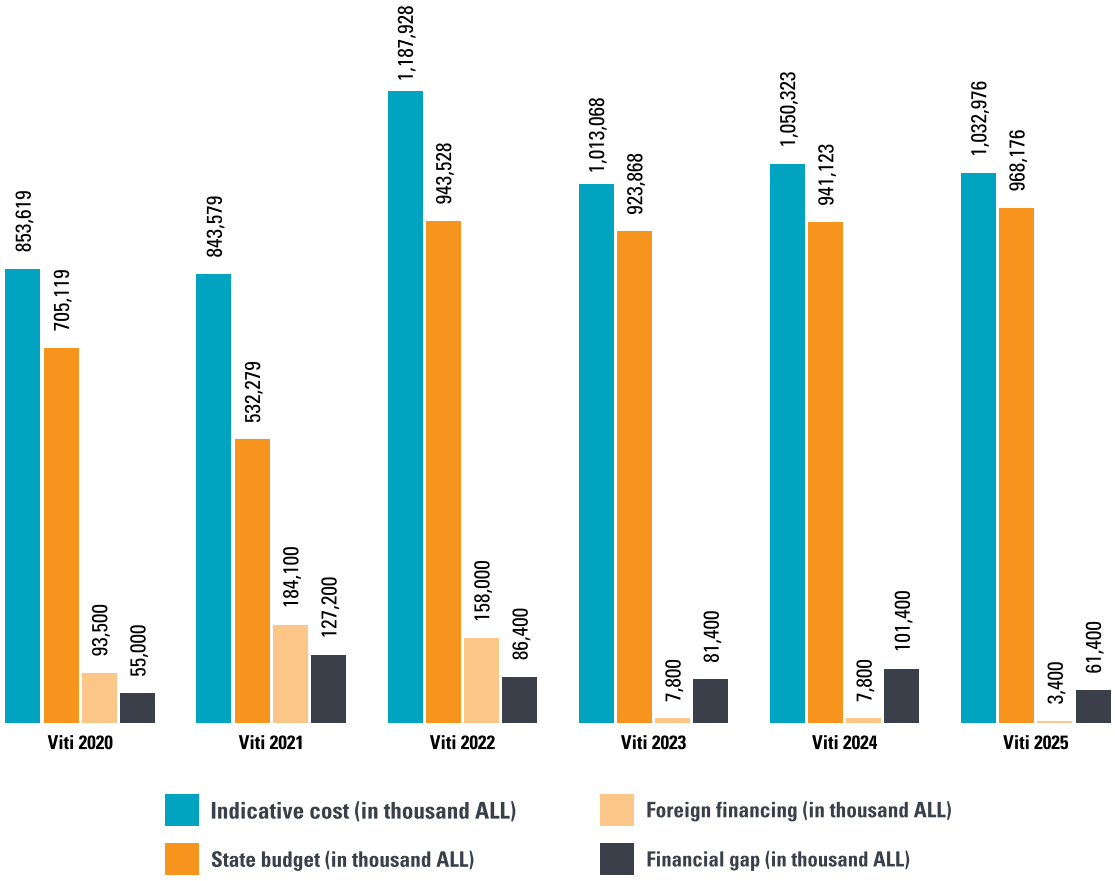
(Insert MTBP program name contributing towards policy goal achievement) (Take into consideration that a Policy Goal may be implemented through more than one budget program) In the case of the PwD Policy Document, examine whether the Policy Goal is financed via one or several Budget Programs.

000/ALL

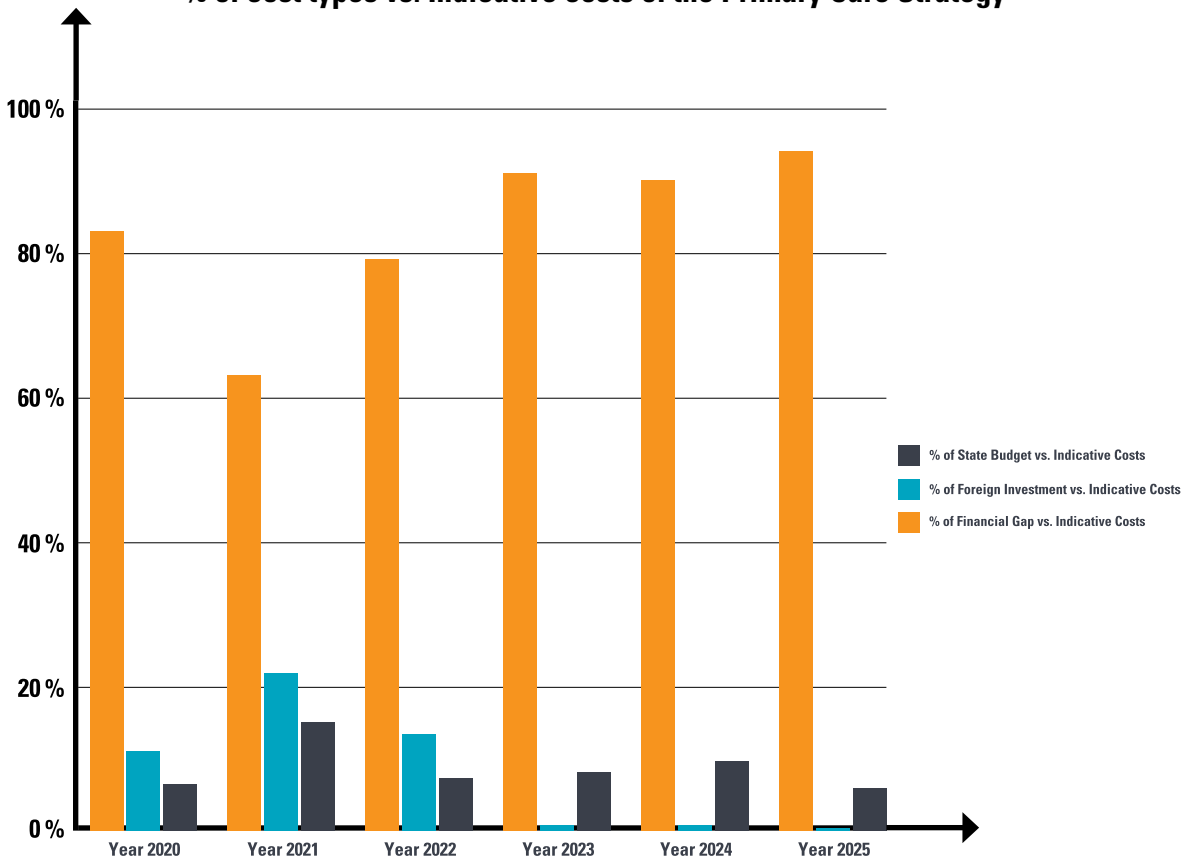
No.		Outcome Reference with budget program outputs	Details of activities	Responsible institutions		Implementation time frame		Indicative costs (in thousand ALL) (these costs are total costs, calculated based on the IPSIS cost formats)	Financing source		Financial gap
						Start Date	End Date		State Budget	Foreign Financing	
	TOTAL							**99,285**	**90,285**	**9,000**	**-**
A.	**IV. SPECIFIC OBJECTIVE 1. Improving the management efficiency of PHC institutions**	**(Filling in this cell concerns only the results, not the objective)**		**Insert the responsible institution (Lead)**	**Contributing institution (if any)**	**4th trimester, 2020**	**4th trimester, 2025**	**97,285**	**88,285**	**9,000**	**-**
A.1	Drafting support policies for a) employment of students with a Health Management Master's diploma, b) CME programs for PHC managers, for recertification and credits related to health institutions management.	Planning Administration Management Code 01110 Output 1: Approved legal and sub-legal acts and Primary Health Care Services Code 07220	Approving rules and legal acts (3 legal acts) Cost of drafting a legal act (or standard) from MTBP, which totals = ALL 9 095 000/act: composed of [ALL 5 595 000 costs (salaries+ soc. sec.) + ALL 3500 000 for operating expenses]. Procuring the equipment package for 1500 doctors (study 5 local experts * 30 days * ALL 30 000) + package worth ALL 500 thousand/doctor + ALL 100 thousand for different medical materials expenses (equipping 300 doctors/ year starting in 2020)	MHSP	CHCIF, HCSOs, HCs	4th trimester, 2020	4th trimester, 2021	27,285	27,285	-	-

No.		Outcome Reference with budget program outputs	Details of activities	Responsible institutions		Implementation time frame		Indicative costs (in thousand ALL) (these costs are total costs, calculated based on the IPSIS cost formats)	Financing source		Financial gap
						Start Date	End Date		State Budget	Foreign Financing	
A.2	Preparing strategic planning models, piloting such models in various selected HCs in collaboration with the staff of said HCs and applying these models in most HCs across the country.	Primary Health Care Services Code 07220	Drafting plans in collaboration with the HC staff. 100 persons included in the existing structures x 2 trimesters: average salary including social securities = ALL 85 000 (the first trimester during 2021-2022 and second trimester during 2023-2024).	HCSOs	LHCUs, HCs, PHI	1st trimester, 2021	4th trimester, 2024	51,000	51,000	-	-
A.1	Supporting the meeting model between HCs and community representatives: a) health centers respond directly to the requests and needs of the community and, b) inhabitants can better understand the services provided and the potentials and limitations of health care.	Primary Health Care Services Code 07220	Organizing systematic meetings. 100 meetings per year * ALL 20 000/ meeting (lump sum)	HCSOs	LHCUs, HCs, CHCIF, PHI	4th trimester, 2020	4th trimester, 2025	10,000	10,000	-	-
A.2	Standardizing the required administrative documentation (packages and document formats to be made available to management teams of health centers electronically and in physical copies).	Primary Health Care Services Code 07220	Preparing and approving instruments. Working group with 10 local experts * 30 working days * ALL 30 000/day (to draft documentation in collaboration with relevant actors)	MHSP	CHCIF, HCSOs, HCs	1st trimester, 2023	1st trimester, 2024	2,000	500		

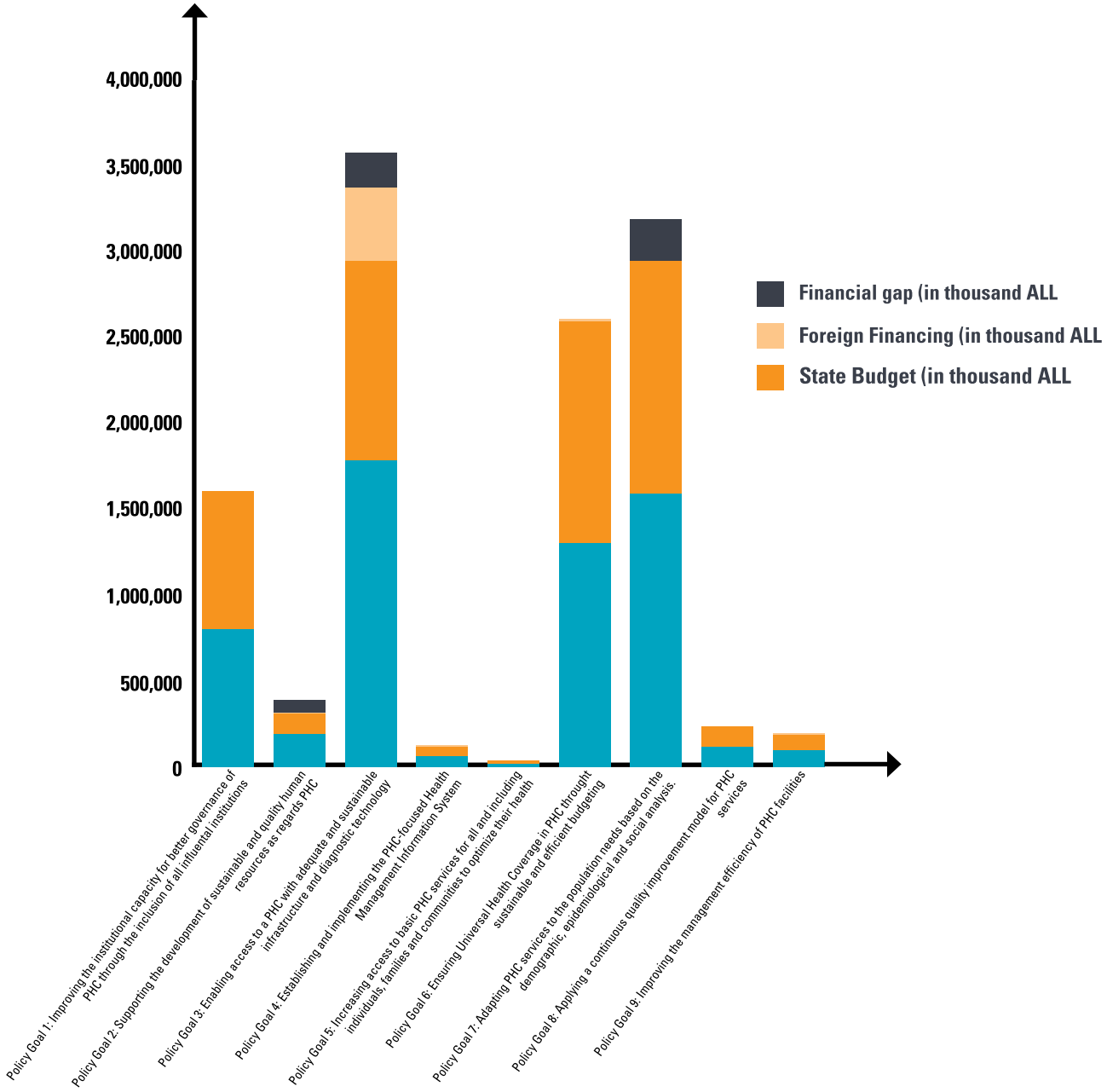
Cost types during 2020-2025 for the Primary Care Strategy



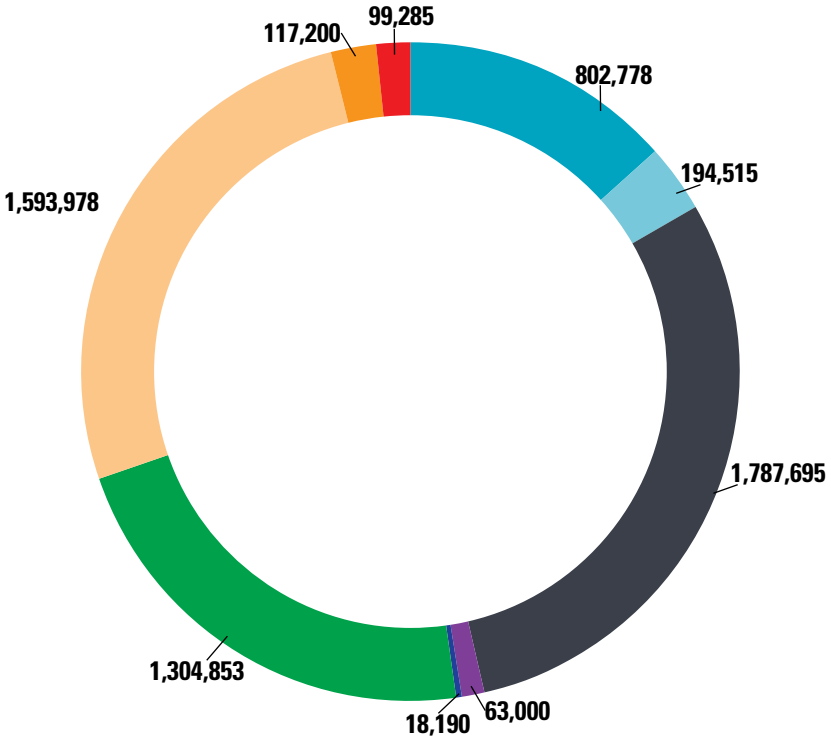
% of cost types vs. Indicative costs of the Primary Care Strategy



Cost types by Primary Care Strategy goals



Indicative Costs by policy issue for Primary Care Strategies (in thousand ALL)



Policy Goal 1: Improving the institutional capacity for better governance of PHC through the inclusion of all influental institutions

Policy Goal 2: Supporting the development of sustainable and quality human resources as regards PHC

Policy Goal 3: Enabling access to a PHC with adequate and sustainable infrastructure and diagnostic technology

Policy Goal 4: Establishing and implementing the PHC-focused Health Management Information System

Policy Goal 5: Increasing access to basic PHC services for all and including individuals, families and communities to optimize their health

Policy Goal 6: Ensuring Universal Health Coverage in PHC throught sustainable and efficient budgeting

Policy Goal 7: Adapting PHC services to the population needs based on the demographic, epidemiological and social analysis.

Policy Goal 8: Applying a continuous quality improvement model for PHC services

Policy Goal 9: Improving the management efficiency of PHC facilities