Mid-term plan of priority actions

As mentioned in Chapter 1, this year the matrices of mid-term priority actions were developed in line with the medium-term budgeting process. This was decided in order to address a criticism made by various stakeholders, not least in the Joint Staff Assessment of last year’s Progress Report, that it is often not clear what the cost of priority policies is and whether they fit into the MTBP. According to the instructions issued by the Ministry of Finance, the preparation of the medium-term budget relies on the contribution of line ministries in 2 steps:

**Programme Policy Review** Ministries describe policy goals and objectives for each programme.

**Programme Expenditure and Investment Planning** Ministries identify target output levels for each of their programmes and allocate sufficient resources from their medium-term budget preparation ceiling to each programme for the delivery of those target outputs. Resource allocations include allocations for public investment.

Only 5 ministries have worked through these procedures this year: Education, Health, Labour and Social Affairs, Agriculture and Food, and Territorial Adjustment and Tourism. In addition, the Ministry of Transport and Telecommunications submitted a review of one of its programmes. Their Programme Policy Review matrices are presented below. A Programme Policy Review is not intended to be a full and comprehensive review of the sort that is required for an update of the NSSED. However, line ministries need to demonstrate that they have:

* identified and described each of their expenditure programmes;
* reviewed the policies relating to each expenditure programme to ensure that a programme policy statement can be written (or revised);
* reviewed the policies so that they are consistent with and reflect wider national policies (NSSED, European integration, NATO accession); and
* identified the status of each of their policy statements (for example, whether any particular policy statement has implicit or explicit Council of Ministers approval)

The NSSED Department took part in the process through the MTBP Secretariat and reviews of the line ministry inputs for consistency with the national strategy.

Of the remaining ministries, the 8 ministries with the largest shares in the budget were asked to prepare a sector expenditure strategy, a less comprehensive procedure to encourage a strategic approach to the planning of public expenditure. The sector strategies identify concisely target outputs, beneficiaries, the current situation, plans for reform and the budget implications for each programme to consolidate the link between budgets and policies. Of these ministries, the following submitted a sector expenditure strategy: Defence, Finance, Industry and Energy, and Local Government and Decentralisation. The NSSED Department was directly involved in assisting the Budget Department in the development of these strategies. The following ministries did not submit a strategy: Culture, Youth and Sport, Environment, Justice, and Public Order.

It must be stressed that the matrices do not yet indicate whether the proposed activities will receive budget funding, as the medium-term budget programme process had not yet been completed at the time of writing. However, their inclusion in the Progress Report is considered essential in showing the links between the NSSED and MTBP processes. This is a first small but significant step for the NSSED Department to assume an increasing role in the formulation of strategies at the sector level. In the context of the Integrated Planning System, the NSSED Department will assume increasing responsibilities over the coordination of sector and crosscutting strategies. The prioritisation process will need to be ever more strategic in linking long-term goals with medium-term policies that are embedded in medium-term budgeting.

* 1. Ministry of Health

Programme 1: Planning, management and administration

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| Policy description | Policy goals | Policy objectives | Policy standards |
| Improve functional structure for adequate management of health system. Conserve integrity of health services structure designing regional health authorities (RHA). Develop strategic and policy papers for health sector. Continuous inspection and monitoring for the sector. | A complete and modern law framework, an adequate financing system, capable human resources in order to fulfil the needs of the health system, as well as a complete information system at all levels of health service. By 2015 all RHA to be delegated 80% of competencies. | Year 1Decentralisation action plan and appropriate financial resources determined based on 3-year national plan of health services development. Information system for human resources established. 1% of staff trained from centre for continuous professional formation. 20% of Ministry staff strengthened as an overall improvement of Ministry’s capacities. New classification for nurse servicing established.Year 2Monitoring of RHA activities based on health standards. 30% of other competencies will be delegated to RHA. Involvement at least one representative from patient protection office in the RHA board in decision-making process. 5% additional staff trained from centre for continuous professional formation. Planning and classification of human resources in national level.Year 3Monitoring of regional RHA activities based on health standards. 10% of other competencies will be delegated to RHA. Personnel distribution and placing in institutions according to the categories and numbers based on national plan. 10% additional staff trained from centre for continuous professional formation. | All the staff that works in the RHA planning departments should be graduates in economics. Every head of institution should have post-university qualification in health management. |

Programme 2: Primary health care services

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| Policy description | Policy goals | Policy objectives | Policy standards |
| Offer quality primary health care services based on curative, preventive and promotional components. Provide autonomy for family doctors as part of primary health care. Accredit/license ambulatory care, mother and child care and oral care. | Better access for health care and services offered according to specified standards. Cover 100% of territory with ambulatory centres until 2010. Reduce under-5 mortality to 10 per 1000 live births until 2015. Reduce maternal mortality by half from 2001 (22.7 deaths per 100,000 live births) to 2015. Create mental health community care system all over the country until 2010. Educate 90% of population (parents, educators, teachers, social and health workers) on principles of oral health care. 90% of children aged 0-6 will benefit from fluorine tablets by 2015. | Years 1-3 – Each year:Cover 10% of rural areas with ambulatory centres. Equip 10% of health centres. Equip 5% of mother-child consulting centres with necessary tools. Expand unified treatment for pregnant women and newborns in maternity hospitals in 2 hospitals. Expand family planning services in 10 health centres. Improve 4% of total public oral heath infrastructure and cover 7% of population with preventive services. Year 1Multidisciplinary mental health community teams (psychologist, psychiatrist, and social worker) created in all prefecture centres. Information system for primary health care completed in 5 regions.Year 2Increase number of contacts with the people served from the multidisciplinary team.Year 3Decrease number of in-patients in psychiatric hospitals. | Primary health care service: At health centres 1 doctor per 2000 habitants in urban areas / 1 health centre for each commune maintaining a ratio of 1 doctor per 1700 habitants in rural areas. At ambulatory centres 1 nurse per village (where there is no doctor)ISKSH lawFamily doctors: 1.3 per 1000 inhabitants1 mental health centre per region1 mental health care centre per 150,000 inhabitants1 dentist per 1500 people aged 0-18 |

Programme 3: Secondary health care services

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| Policy description | Policy goals | Policy objectives | Policy standards |
| Provide hospital health care at all levels for better access, satisfactory quality and effective cost management. Improve hospital management by establishing autonomous hospitals. Improve service quality by introducing the guidelines of clinic practices, accreditation system, continuous training of personnel, standardised maintenance of medical equipment and performance evaluation based on respective indicators. | Develop modern practices of hospital management by 2005: developed system of clinic and financial information, as well as monitoring system measuring hospital performance. | Year 1Improve human resources and financial management in 20% of regional hospitals. Increase number of patients in need for specialised oculist care and ORL as ambulatory patients. 40% of haemodialysis needs covered each year. Increase by 30% the number of patients that will benefit from the expansion of Durres hospital. Establish legal framework for accreditation. Establish performance evaluation process for hospitals. Cover blood needs by 100%.Year 2Improve human resources and financial management in a further 30% of regional hospitals. Increase by 30% the number of patients that are in need for specialised oculist care and ORL as ambulatory patients. Maintain 40% of haemodialysis needs covered each year. Cover blood needs by 100%. 20% of hospitals supported in accreditation process. Eliminate hospital waste by 20%.Year 3Improve human resources and financial management in a further 30% of regional hospitals. Increase by 30% the number of patients that are in need for specialised oculist care and ORL as ambulatory patients. Cover 50% of haemodialysis needs. Cover 100% of blood needs. Additional 40% of hospitals supported in accreditation process. Eliminate hospital waste by 40%. Establish transplant treatment service. | Provide hospital service at regional level for a population of 200,000 inhabitants.Provide hospital service at district level for a population of 100,000 inhabitants.Providing the hospital service in rural level for a population of 20,000-40,000 inhabitants daily.Develop quality standards (accreditation) according to the ALFA standards for Albanian hospitals. |

Programme 4: Public health services

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| Policy description | Policy goals | Policy objectives | Policy standards |
| Conserve and improve population health, prevent infectious and chronic diseases through the surveillance system as well as implement appropriate measures and programs in cooperation with family doctors. | Vaccine shots / mandatory immunisation covered (100% and over 95% respectively).No cases of poliomyelitis and measles; very rare and sporadic cases of German measles, diphtheria, and tetanus.Decrease number of hepatitis B infants. Strengthen epidemiology surveillance and monitoring of potable water.Prevent epidemic outbreaks; decrease each year the number of people infected by water-borne diseases by 5%.Establish and equip public health laboratories by 2015.Improve and approximate current legislation with EU. | Years 1-3 – Each year:Increase proportion of regions that report on illnesses in time with high quality information by 10%. Improve level of epidemiologists, sanitary inspectors as well as other public health professionals. Increase health planning and management capacities.Year 1Review HIV/AIDS and mental health laws. Introduce haemophilus influenza vaccine. Prepare list of environmental health indicators. Prepare guideline for investigation of epidemic outbreaks. Year 2Review infectious diseases and sanitary inspectorate laws. Introduce parotid vaccine.Year 3Establish public health laboratories in 12 regions with developed standards. Legalise public health school. | Shift from national to EU standards. |