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ALGERIA

STRENGTHENING HEALTH SYSTEM GOVERNANCE: TOWARDS MORE EFFECTIVE REGULATORY ENVIRONMENT FOR IMPROVED EFFICIENCY AND QUALITY OF CARE

CONCEPT NOTE FOR TECHNICAL ASSISTANCE (P102401)

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MIDDLE EAST AND NORTH AFRICA
HUMAN DEVELOPMENT GROUP (MNSHD)

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TABLE OF CONTENTS

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1. BACKGROUND

The health sector currently accounts for about 4.3 percent of GDP. The right of all citizens to health care is enshrined in the Constitution of the Democratic and Popular Republic of Algeria of 1989 and 1996. This has resulted in a system where healthcare services are predominantly publicly financed and delivered, albeit with limited but increasing private participation.

The country continues to make considerable efforts to ensure access to health services to its population, but significant challenges remain. Since independence, health indicators have improved dramatically. However, there are major issues regarding equitable access to care, especially in southern part of the country; inherent allocative and technical inefficiencies due to a hospital-centered delivery model and poorly functioning primary health care network and dyfunctional hierarchy across levels of health care; and dissatisfaction of the population with the technical and psycho-social quality of care provided in public facilities who increasingly seek care in the burgeoning private sector and pay out of pocket. On the other hand, the Government of Algeria (GoA), trying to catch up with the time lost in 1990s, has, during the last two five-year planning cycles, considerably increased public investment in the health sector. By 2009 this will result in a very large and comprehensive health infrastructure and adequate number of human resources, putting considerable financial and fiscal pressure on the economy and state budget unless timely measures are taken to improve system governance and introduce the right mix of incentives to improve overall efficiency. This pressure will be all the more significant given the rapid demographic and epidemiologic transition so long as the State is intent on safeguarding the rather generous coverage and benefit package.

To respond to these challenges, ambitious reforms are needed. Although preparatory work has been conducted since 2002 (a comprehensive bill was drafted in 2003, among others), progress has been very slow. The difficulty in carrying out the reforms can be largely explained by the low capacity of the Ministry of Health, Population and Hospital Reforms (MHPHR) in human resources and technical infrastructure such as the health management information system. There is an implicit acknowledgement of the inherent weaknesses of the current healthcare system through various reports (see for instance the latest report entitled La Santé des Algériennes et Algériens) but not necessarily explicitly through formal issuance of a White Paper on national health policy and strategy development.

World Bank's involvement in policy dialogue in the health sector is relatively recent. Upon request of the Ministry of Labor and Social Security (MTSS), the Bank conducted in April 2005 a review of the pharmaceutical sector, leading to two workshops in June and December 2005 and issuance of the final report in February 2006 with concrete recommendations (see Section 4 for details).

The health sector was included in the Public Expenditure Review that was presented to the Algerian authorities in July 2006. This has updated Bank's previous review of the sector which was carried out by in 2001 in the context of the *Review of Social Expenditures,* and helped formulate reform measures and propose further technical assistance that could support the preparation and implementation of the reforms.

Subsequently, in a meeting with the Bank health team in April 2006, the Minister of Health asked for Bank assistance in three areas: (i) pharmaceuticals policy; (ii) provider payment mechanisms,

to prepare the implementation of contractual relationships between the Social Security system and hospitals; and (iii) the delegation of the management of public hospitals to the private sector. The first request constitutes a follow up to the TA provided last year, and is meant to go deeper in specific areas such as setting prices for pharmaceuticals. For the second request, the Bank has agreed to support the development of appropriate costing and quality auditing capacity in the system in preparation for the contracting arrangement. As for the last request, the Bank provided TA last fiscal year in the form of a workshop to present different approaches to private management of hospitals. In the following discussions, it was agreed that the GoA will first need to complete their legal and legislative reviews on private contract management before moving to the next implementation step. The scope of the Bank's TA will be determined after they complete their legal and legislative reviews.

This concept note describes the scope, purpose and organization of the proposed technical assistance requested by the GoA. It is organized in five sections. Section 2 and 3 set the context for the proposed program by briefly reviewing the healthcare system and describing the main reform issues the technical assistance seeks to address. Section 4 describes the three components of the program and the proposed methodology. Finally, Section 5 provides the details regarding the task team, work plan, and budget.

2. OVERVIEW OF THE HEALTH CARE SYSTEM IN ALGERIA

The Algerian healthcare system has achieved impressive results in terms of health and access to health care. Geographic access to health facilities is measured at 98 percent of the population. The whole population has financial coverage for health care services, at least in the public sector. As a result, health indicators have improved dramatically. Life expectancy at birth averaged 71 years in 2004, having increased from 53.5 years in 1970. The under-five mortality rate decreased from 134 per 1,000 children in 1980 to 40 in 2004 and if it continues to decrease at the same pace, the Millennium Development Goal (MDG) on child mortality will be reached (see Figure 1). However, the maternal mortality ratio (MMR) shows no consistent improvement and is higher than in countries of comparable GDP per capita. In 2000 the MMR was at 140 per 100,000 (down from 160 per 100,000 in 1990). At present trends, Algeria is unlikely to meet the MDG Goal of ¾ reduction in 2015 (see Figure 2).

Figure 1 MDG 4 Child Mortality

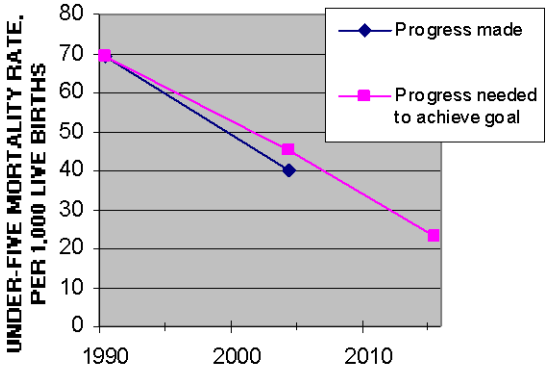
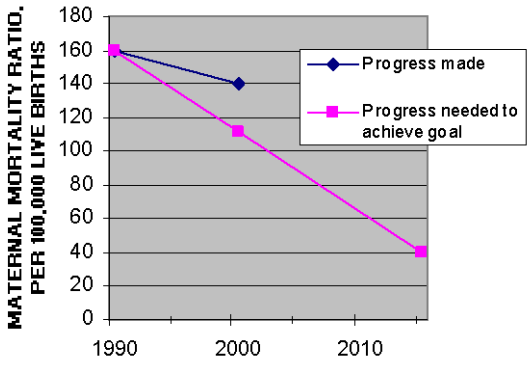


Figure 2 MDG 5 Maternal Health



Source: World Development Indicators 2006; Maternal Mortality in 2000 (WHO, UNICEF, UNFPA)

In the near future, the health care system will face very significant financial and fiscal challenges. At 4.3% of GDP in 2002, the overall level of expenditures devoted to health is relatively low in comparison with other countries of similar income level (Table 1). However, over the short and medium term, Algeria will face sharply higher health spending needs due to the demographic and epidemiologic transitions, the use of new medical technologies and costly new drugs (Figure 3), the probable increase of health professionals salaries in the public sector, and the ongoing revision of the 1987 rates used by the Social Security system to reimburse private medical treatment. These financial constraints will be reinforced by the fact that the Algerian healthcare system is still deeply influenced by the doctrine of free care to all, which explains why nearly all curative and preventive care possible are provided in the public sector in exchange for a very modest contribution. Finally, despite the recent increase in oil revenues, the tax and therefore revenue base in Algeria is limited due to widespread tax evasion.

Table 1: Health Expenditures: International Comparison

COUNTRY	GDP p.c. (USD)	Health expenditure p.c. (in USD)	Health expenditure p.c. (in 2002 USD PPP)	Health expenditure, public (%GDP)	Health expenditure, private (%GDP)	Health expenditure, total (%GDP)
ALGERIA	**1823**	**77**	**249**	**3.2**	**1.1**	**4.3**
EGYPT	1600	59	174	2.4	3.6	6.0
IRAN	1630	104	340	2.9	3.1	6
JORDAN	1796	165	375	4.3	5	9.3
MOROCCO	1234	55	172	1.5	3.1	4.6
TUNISIA	2122	126	396	2.9	2.9	5.8
MENA REGION	1789	80	n/a	2.5	2.9	5.4
MIDDLE-INCOME COUNTRIES	1829	107	n/a	2.9	3.1	6
LOWER MIDDLE-INCOME COUNTRIES	1324	75	n/a	2.5	3.3	5.8

Source: WDI 2005 – 2002 data

The healthcare system has inherent weaknesses in terms of equitable access to care, efficiency and quality of care. In a system which relies heavily on hospitals for service provision, the occupancy rates are very low (Table 2). The various levels of health care are not being used properly due to the dysfunctionality of the system hierarchy across levels of healthcare. Primary and secondary care facilities are under-utilized or bypassed as many people prefer to turn directly to university or specialized hospitals for consultations. Absence of public investment in the infrastructure in the 1990s resulted in dilapidated facilities and outdated, obsolete or broken equipments seriously affecting quality of care. In terms of equity, despite a dense and highly structured network, physical access in rural areas is hampered by lack of equipment, drugs and

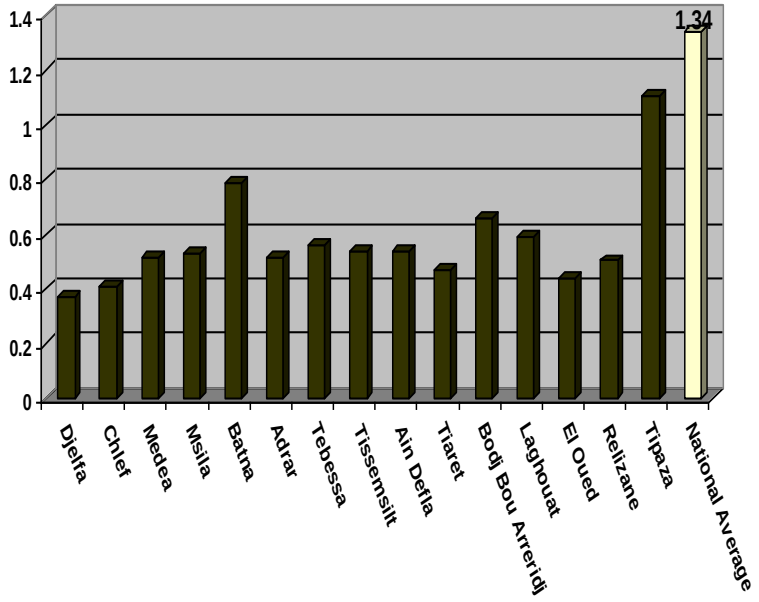
medical staff (see figure 3). In addition, due to the low quality of technical and psycho-social care provided in the public realm, the private sector is growing fast in an unregulated fashion leading towards a two-tiered system with better quality care for those who can pay out of pocket and thus increasing inequalities in access to care.

Table 2 Outpatient and inpatient utilization in publicly funded health facilities, 2003

	Beds	Admissions	Days of hospitalization	Consultations	Occupancy rate (%)	ALOS
Secteurs sanitaires	32970	1343828	5255761	37237607	**44%**	3.9
EHS	5961	117988	1422469	1111688	**65%**	12.1
CHU	12375	429242	2757099	4120792	**61%**	6.4
Total	51306	1891058	9435329	42470087	**50%**	5.0

Source: MHPHR, Health Statistics, 2003

Figure 3 Number of Physicians/1,000 Inhabitants in the "Poorest Wilayas", 2004



Source: MOH (Health Map), Poverty Map (2001)

The current situation results from poor stewardship and poor overall governance and management of the healthcare system. First, there are severe institutional problems such as an excessive compartmentalization of system governance at the central level, lack of clarity in terms of the extent of decentralization and insufficient leadership and a professional cadre to steward the system and reduce fragmentation. This is all the more evident in the lack of a national health policy and strategy with a mid to long term vision for the sector that would define the respective roles and responsibilities of the various stakeholders in the public sector and non-governmental professional organizations. Second, there is a high degree of confusion as to how hospitals should be governed, managed and administered and which functions could be devolved for them to operate in a more autonomous and efficient manner. Finally, there does not seem to be any

serious attempt to estimate the future health and healthcare needs and the resource, human, physical and financial, requirements to respond to the changing needs of the population.

Instead, the emphasis is placed on finding solutions at the organizational and instrumental levels, which, while certainly relevant and potentially effective, are, nonetheless unlikely to resolve the existing weaknesses unless major policy decisions are made an a consensus is build around a sound sectoral strategy. The reform issues in the next section are not, however, discussed from the perspective of a broader or systemic perspective, but rather as perceived by the current MHPHR leadership and administration.

3. MAJOR REFORM ISSUES

The main focus of the proposed reforms is targeted towards: (i) the implementation of contractual relationships between the Social Security system and the MHPHR; (ii) a new status for public health institutions that will grant them more autonomy; (iii) the development of a comprehensive health information network; and (iv) the development of appropriate policies for pharmaceuticals (including pricing, generics promotion, procurement of hospital drugs, etc.).

The priorities identified by the Bank are consistent with the current reform agenda of the Algerian government. The main recommendations issued by the Bank are the following:

- *Reinforce planning and management capacities*. This would require strengthening the human resources needed for managing the system at the central level (IT technicians, statisticians, actuaries, and health economists), improving training for system managers, and developing information systems at all levels.

- *Improve the institutional framework.* This would require reinforcing coordination among the principal ministries involved in the health sector, reorganizing the central structure of the Health Ministry to promote greater policy consistency, setting up regional health agencies and giving more autonomy to hospital managers.

- *Rationalize the use of the different levels of care.* This would require reinforcing the primary and secondary levels, developing a "gatekeeper" system and taking into account the private sector.

- *Reform the financing system.* First, this would require increasing financial maneuvering room through better control over expenditures, a diminution of "social evasion", the definition of a benefits package, and an increase in the financial contribution of households. Second, it would be necessary to implement contractual relationships between the Social Security system and the Health Ministry as soon as possible. Since the 1992 budget law, the financing of public health facilities is supposed to be shared "on the basis of contractual relationships between the Social Security system and the Health Ministry". But these legal provisions have never been applied and the delay in moving to contractual relationships for the financing of public health facilities is damaging to the health care financing system. Both the State budget and the Social Security system behave as "passive buyers" of health care, and there is no real separation between care payer and care supplier that might encourage health institutions to improve the efficiency and quality of their services.

4. COMPONENTS OF THE TECHNICAL ASSISTANCE PROGRAM

The proposed technical assistance program consists of three core components, based on the agreement the Bank health team has recently reached with the MHPRH. It augurs well with GoA's request detailed above in the following ways: (i) provider payment mechanisms and delegation of management of health facilities to the private sector, especially those applicable to hospitals require, first and foremost, a sound assessment of the costs and quality of inpatient care so that pricing and volume of medical activities which will from the basis of contractual arrangements could be set, monitored and managed effectively; and (ii) setting prices for pharmaceuticals is a key ingredient to a sound pharmaceutical policy. The components are briefly discussed in this section.

COMPONENT 1: SETTING PRICES FOR PHARMACEUTICALS

The specific objective of this component is to assist the GoA to design a mechanism to set prices for pharmaceuticals either produced nationally, or imported from other countries. The technical work will take stock of a previous advisory assistance provided to the Ministry of Labor and Social Security (MTSS) which provided a broader picture of the pharmaceutical sub-sector in Algeria which accounts for about 33 percent of total public expenditures on health. The report which was published in February 2006 concluded that while Algeria currently spends about US$23 per capita on pharmaceuticals, there are considerable inflationary trends due to epidemiologic and demographic transition, introduction of more costly new drugs into the market and the eventual increase in the importation of drugs as a result of the on-going liberalization of the Algerian economy and the significant pending increase in human and physical resources between during the current decade (1999-2004 and 2005-2009 planning cycles). The report made nine recommendations touching various aspects of sub-sectoral policy, organization, governance and regulation and development of tools for enforcement of regulatory and quality standards. Setting prices for pharmaceuticals is one of the main recommendations which generated a high degree of interest, leading to a specific request from the GoA for technical assistance.
The technical work consists of:

- Reviewing the existing mode(s) of price setting in Algeria for both generic and branded drugs either imported or produced in locally;
- Proposing a set of criteria and standards for price setting (therapeutic value, efficacy, costs, side effects, quality of life, etc.);
- Proposing a governance and regulatory mechanism and a more transparent due process whereby prices will be set after consultation with stakeholders (MSPRH, MTSS, CNAS, CASNOS, INSP, Ministry of Industry, Ministry of Commerce, Ministry of Finance, etc); and
- Revising/amending the existing decrees and ordinances related ot setting prices of pharmaceuticals.

The main audience for the technical work under this component will be the MOHPHR (mainly the Department of Pharmaceuticals), MTSS, CNAS and CASNOS.

COMPONENT 2: ESTIMATING COSTS FOR INPATIENT CARE

The specific objective of this component is to assist the MSPRH to develop and implement a methodology and tools to estimate real (direct and indirect costs) of episodic care in hospitals of

different degree of specialization and vocation for a select list of tracer conditions. As such this study will complement a previous study carried out by the MSPRH which estimated the inpatient costs, albeit using clinical and surgical department as the unit of analysis. The proposed technical work will take this line of investigation further by using the most common causes of hospital admission as units of analysis. The results of this analytical work will provide a better understanding of the cost-quality trade-off and consequently help MSPRH and the CNAS to design and develop volume- and quality-based contracts with hospitals as informed purchasers rather than passive buyers.

In addition, technical work under this component could be used as a backgrounder for highlighting variations in costs and quality across units, departments, hospitals of different vocation and level of specialization and thus for establishing costing standards, at least for the most common causes of inpatient admission.

Finally the findings of this technical work could also be used to inform policy makers and health care managers of areas where resources could be conserved and efficiency in inpatient healthcare delivery improved. A limited study is being pursued due to both restricted time availability and funding, but also a full costing study covering the whole range of inpatient care episodes would not be cost-informative at this juncture. However, the methodology to be developed through this analytical work should form the basis and be easily replicable for a larger subsequent study.

The technical work will consist of:

- Preparation of a draft methodology and study protocol for estimating inpatient costs and assessing quality of care;
- Agreement with Algerian stakeholders on the methodology and protocol and the site of the costing survey;
- Survey of selected hospitals and preparation of the final report; and
- Presentation of the final report to Algerian stakeholders for discussion and clearance.

The main audience and therefore beneficiaries of the technical assistance under this component are MHPRH and CNAS.

COMPONENT 3: AUDITING TECHNICAL QUALITY OF INPATIENT CARE

The specific objective of this component is to assist the MSPRH to develop and implement a methodology and tools to assure and control the quality of care in hospitals of different degree of specialization and vocation for a select list of tracer conditions. The results of this analytical work will provide a better understanding of the cost-quality trade-off and consequently help MSRH and the CNAS to design and develop volume- and quality-based contracts with hospitals as informed purchasers rather than passive buyers.

In addition, technical work under this component could be used as a backgrounder for highlighting variations in costs and quality across units, departments, hospitals of different vocation and level of specialization and thus for establishing quality of care standards, at least for the most common causes of inpatient admission.

Finally the findings of this technical work could also be used to inform policy makers and health care managers of areas where resources could be conserved and efficiency in inpatient healthcare delivery improved. A limited study is being pursued due to both restricted time availability and funding, but also a full quality audit covering the whole range of inpatient services would not be

cost-informative at this juncture. However, the methodology to be developed through this analytical work should form the basis and be easily replicable for a larger subsequent study.

As with Component B, the technical work will consist of:

- Preparation of a draft methodology and study protocol for estimating inpatient costs and assessing quality of care;
- Agreement with Algerian stakeholders on the methodology and protocol and the site of the costing survey;
- Survey of selected hospitals and preparation of the final report; and
- Presentation of the final report to Algerian stakeholders for discussion and clearance.

The main audience and therefore beneficiaries of the technical assistance under this component are MHPRH and CNAS.

5. WORK PLAN, TASK TEAM AND COSTS

The task team includes Enis Baris (Senior Health Specialist MNSHD, TTL and Responsible for conceptualizing and integrating technical work across all components); Axel Rahola (Economist, HDNHE, Responsible for managing and overseeing work under components 2 and 3), Vincent Houdry (Consultant, expert in pharmaceuticals regulation and pricing) and Cristian Morales (Consultant Economist, expert on cost estimation and quality of care in hospitals). In addition, a consultancy firm will be hired to conduct the field work under components 2 and 3.

The peer-reviewers for the task are Eric De Roodenbeke (Sr Health Specialist, Hospitals, AFTH2) and Andreas Seiter (Sr Health Specialist - Pharmaceuticals, HDNHE and expert in pharmaceuticals).

The total cost of the tasks for FY07 is estimated at USD 195,000 (see Table 1 below). The schedule of activities is presented in Annex 1.

TABLE 3: TASK TEAM AND BUDGET FOR FY07

Staff / Consultant	Weeks	Travels	Total
Enis Baris (TTL) integration and drafting of final report	12	4	**70,000**
Component I: Setting prices for pharmaceuticals			**40,000**
Vincent Houdry (Consultant)	4	3.0	30,000
Axel Rahola (Economist)	2	2.0	10,000
Component II: Estimating inpatient care costs			**47,500**
Cristian Morales (Consultant)	1	0.5	7,500
Axel Rahola (Economist)	2	2.0	10,000
Consultant (Firm)	5	2.0	30,000
Component III: Auditing technical quality of inpatient care			**37,500**
Cristian Morales (Consultant)	1	0.5	7,500
Consultant (Firm)	5	2.0	30,000
TOTAL			**195,000**

TABLE 4: WORK PLAN

COMPONENT / ACTIVITIES	Sep.	Oct	Nov.	Dec	Jan	Feb	Mar	Apr
A. Setting prices for pharmaceuticals								
Review of the current legislative and regulatory framework	X	X	X					
Consensus building with MOH on a proposal for Algeria				X				
Final technical note on price setting			X		X	X		
B. Estimating inpatient care costs								
Preparing a proposal and methodology for a pilot survey				X				
Consensus building on the survey design and methodology				X				
Survey of a select number of hospitals with varying vocations					X	X	X	
Final technical note on cost estimation							X	
C. Auditing technical quality of inpatient care								
Preparing a proposal and methodology for a pilot survey				X				
Consensus building on the survey design and methodology				X				
Survey of a select number of hospitals with varying vocations					X	X	X	
Final technical note on quality of care							X	
D. INTEGRATION								
Policy Note							X	X