HiT summary

Albania

Introduction

Government and recent political history

Albania had a Communist government between 1944 and 1991, during which it pursued a policy of independence and isolation that contributed to its slow development and sustained poverty. Under the constitution of 1998, executive power rests with the president and a unicameral parliament of 140 members.

Population

Albania has a population of 3.1 million, which is younger than that of other European countries, with 40% of the inhabitants younger than 18 years of age. In all, 58% live in rural areas. An estimated 750 000 people left the country between 1990 and 1999. Albania is one of the poorest countries in the WHO European Region.

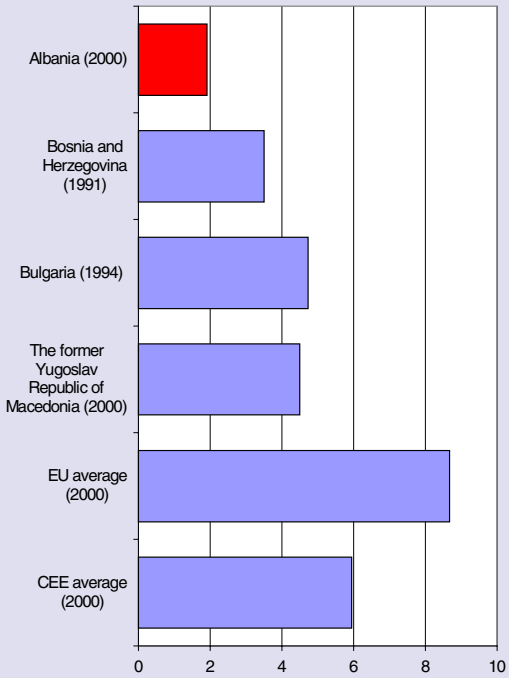
Average life expectancy and infant/ maternal mortality

The Albanian population enjoys reasonably long life expectancy: 68.5 years for men and 74.3 for women (1995; more recent figures are not available). Its longevity is attributed to the good nutrition of the traditional Albanian diet. Infant mortality estimates vary considerably, ranging from 17.5 deaths per 1000 live births in 1999 (Ministry of Health) to 28 per 1000 live births (United Nations Children's Fund (UNICEF)); the high rates are mainly due to the poor quality of maternity services. Maternal mortality, though still high at 17.5 per 100 000 in 1999, has been dropping steadily.

Leading causes of death

The leading causes of death are circulatory diseases, cancer, and accidents and injuries.

Fig. 1. Total health care expenditure as % of GDP, comparing Albania, selected countries and CEE and EU averages



Source: WHO Regional Office for Europe health for all database.

Recent history of the health care system

Before the Second World War, Albania had very few health care professionals (111 doctors and 39 dentists in 1932), and very few people had access to health care services. During the Communist period, the health care system was patterned along Semashko lines. Due in part to extreme poverty and isolation, the quality of services and level of medical technology were

European Observatory on Health Care Systems
WHO Regional Office for Europe
Scherfigsvej 8
DK-2100 Copenhagen
Denmark
Telephone: +45 39 17 17 17
Fax: +45 39 17 18 70
E-mail: observatory@who.dk
www.observatory.dk

very low. Following the collapse of the Communist system, the health care system suffered further setbacks due to violence in 1991–1992, which resulted in the destruction of almost a quarter of city health centres and one third of village health posts. Further violence in 1997 led to looting of drugs and equipment, and about 30% of the country's medical staff abandoned their posts. During the Kosovo crisis, enormous challenges were posed by the arrival of large numbers of undernourished and ill refugees.

Reform trends

Since the early 1990s, the government has had two overriding objectives: (1) to prevent further deterioration of basic services, and (2) to transform the health care system into one that is financially sustainable. Changes have involved efforts to develop a PHC system, to introduce additional sources of finance (social health insurance) with market elements, and to decentralize management of the health care system.

Health care expenditure and gross domestic product (GDP)

According to Ministry of Health estimates, total health care expenditure as a share of GDP was about 3% in 2000, which was substantially below the averages of the European Union (EU) and central and eastern Europe (CEE). About two thirds of this figure represented public spending and one third private, out-of-pocket spending.

Overview

Albania has embarked upon major health sector reforms, but it has been hampered by political instability and a struggling economy. Health care spending is low and must be increased if services are to improve. The establishment of a health insurance system has been a relative success, though large segments of the population are not yet making financial contributions. Privatization of drug distribution has improved drug availability, but increasing out-of-pocket payments for drugs and services has reduced access for lower income groups. Some stability in the system has been preserved through the slow pace of change in the system's financing and organization.

Organizational structure and management

The basic structure of public administration in Albania has continued largely unchanged since the advent of multiparty democracy, as has the structure of the health care system. However, two public administration reforms in 1993 have affected the health care system:

1. the creation of 12 regional prefectures, which have assumed some of the central government's administrative authority; and
2. the strengthening of the role of local government, a change which shifted some responsibility for PHC to rural areas.

Overall, however, the health care system still remains highly centralized and hierarchical.

The Ministry of Health remains the major funder and provider of health care. It has been reorganized, and continues to assume the lead role in most areas of health care.

A government decree of 2000 created the Tirana Regional Health Authority as a pilot organizational form that integrates primary care services and public health programmes. It is hoped that this pilot, which has received assistance from the United Kingdom Department for International Development (DFID) and the World Bank, will pave the way for the Ministry of Health to delegate more authority to regional bodies.

The introduction of social health insurance in 1995 involved the establishment of the Health Insurance Institute, a national statutory fund, which is gradually extending coverage of services in planned stages.

Private health services made their appearance in the early 1990s and new legislation paved the way for the development of various private services: most of drug distribution, most of dentistry, and some limited medical care (diagnostic centres and specialized outpatient care).

There are many active nongovernmental organizations (NGOs) in Albania, some of which are large and well organized (such as the Albanian Red Cross).

Health care financing and expenditure

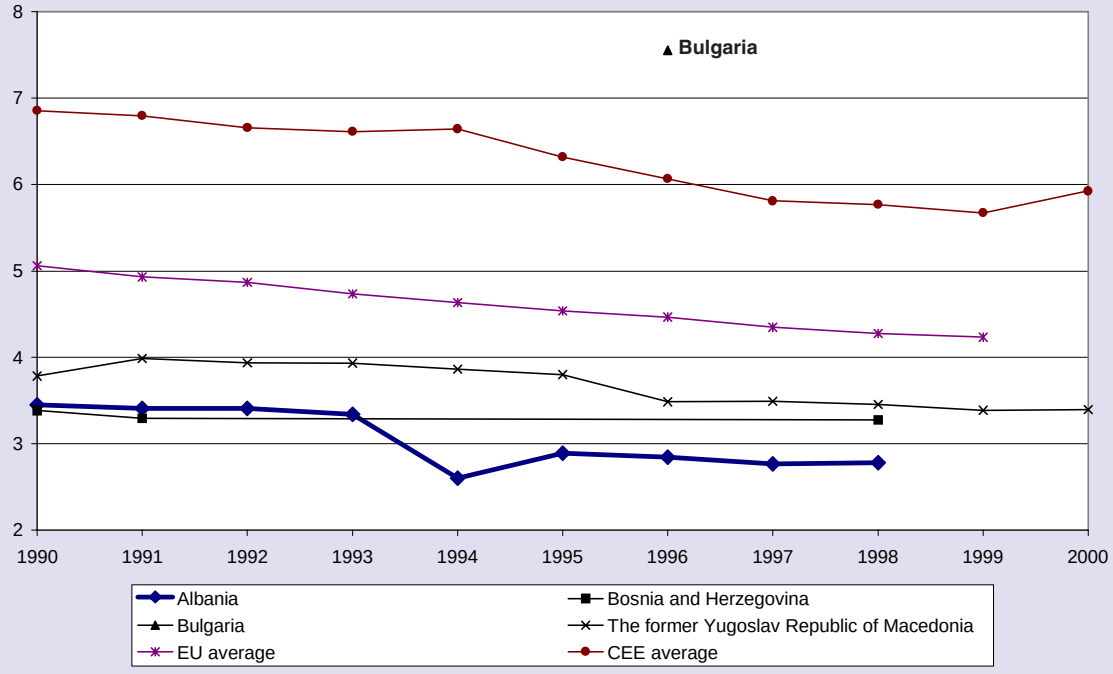
Health care financing

Albanian health care services are financed through a mix of taxation and statutory insurance. The bulk of financing comes from the state budget, but the tax base is problematic due to low incomes, a large informal economy and problems collecting taxes. In 1999, health care was financed as follows: 59% from the state budget, 29% from household payments (including payments to statutory insurance), 4% from employer health insurance contributions and 8% from foreign donors. The Health Insurance Institute received more than 17% of these health funds, including 8.5% that came from the state budget, 4.3% from employers, and 4.4% from individual premiums.

While the state remains the main source of funds, its contribution has shrunk from around 84% in 1990 to 59% in 1999 as other sources of funds, mainly private, increased their share.

The Health Insurance Institute remains by design a limited scheme. Premiums have been kept low, with different rates for different income groups. The scheme purchases a restricted package of health care services.

Fig. 2. Hospital beds in acute hospitals per 1000 population, Albania, selected countries and CEE and EU averages



Source: WHO Regional Office for Europe health for all database.

Complementary sources of finance

Patient co-payments are set at a low level and are not intended to be a major source of revenue. They apply mainly to outpatient services and pharmaceuticals, and not to inpatient care. A 2000 household survey estimated private payments to providers, including under-the-table payments, to be just under one fourth of total out-of-pocket spending; however, this figure is likely to be an underestimate in view of benchmark comparisons with illegal payments in other countries. Most illegal payments to providers are made in state hospitals.

Private insurers have not sought to enter the Albanian market due to the economic and political conditions.

External aid accounts for a sizeable proportion (8%) of total health care financing, and comes from foreign governments and NGOs.

Health care benefits and rationing

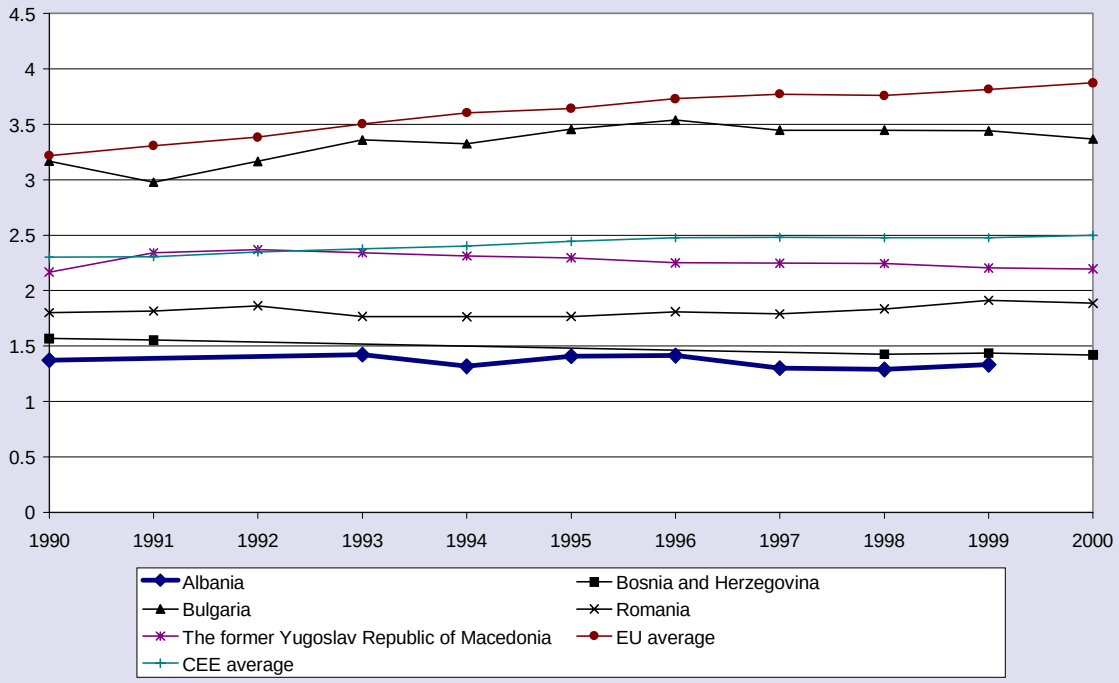
Eligibility for health care is currently based on citizenship and health insurance contributions. The state is responsible for paying contributions on behalf of low-income groups. Access to free primary care is in theory restricted to those who have paid their social insurance contributions; however, in practice no one is denied services. Inpatient services at public facilities are, by law, offered free of charge to the entire population, though the quality of care is often low, and under-the-table payments are prevalent.

Access to health care services is restricted by the system's inability to offer a full range of services and to replace the facilities that were damaged during periods of social unrest.

Health care expenditure

Spending on health care peaked in 1991 at nearly 5% of GDP, only to fall dramatically in subsequent years. The Ministry of Health estimates total spending on health care to have been 3% of GDP in 2000. The public share of spending has fallen to about 2% of GDP. Health care spending remains very low and is not at all sufficient to provide quality health care to all Albanians.

Fig. 3. Physicians per 1000 population, Albania, selected countries and CEE and EU averages



Source: WHO Regional Office for Europe health for all database.

Health care delivery system

Primary health care

In rural areas a typical health centre is staffed by up to three PHC doctors plus nursing staff. Most of the doctors have not been trained in PHC. Rural health posts are typically staffed by a nurse or midwife and provide maternity care, child health services and immunizations. Some of these facilities have ceased to function due to damage they suffered in periods of civil unrest.

In urban areas large polyclinics provide specialist outpatient care and are also used by patients as the first point of contact with medical care. The referral system formerly in place is no longer functioning. While fees have been imposed on those who bypass the referral system, this disincentive has had little effect. Specialists, very often paid under-the-table, have strong incentives to encourage patients to bypass PHC services.

A PHC policy developed in 1997 with EU support aims at providing at least one health centre in each commune and one health post in each village. Many health centres have been rebuilt or renovated with external support. The policy further proposes that general practitioners (GPs) lead primary care teams, which are supposed to act as gatekeepers for the system.

The Ministry of Health, with donor assistance, has begun a process of integrating separate health services into PHC teams. As part of this programme, tuberculosis prevention, as well as school health, health education and other public health programmes, will become part of PHC.

Public health services

The Institute of Public Health, reorganized in 1995 from the previous research institute in hygiene and epidemiology, is accountable to the Ministry of Health and is responsible for collecting public health statistics, organizing health surveys, running immunization programmes, monitoring the environment and collecting data on health status. It also offers advice on public health policy, provides technical support and acts as a national research and training centre.

Much of the responsibility for public health lies with district public health directorates and PHC directorates, which have two distinct structures and sets of responsibilities.

Albania is an "epidemic-prone" country, and the Institute of Public Health, WHO and UNICEF have drawn up contingency plans for epidemics. One reason for its vulnerability is the widespread lack of basic amenities, including access to piped potable water and sewerage.

The Ministry of Health has put considerable effort into achieving good immunization coverage of children and maintaining cold chain conditions for vaccines. In 1999, over 90% of children were immunized against a range of infectious diseases.

Inpatient care

Hospitals remain publicly owned, mostly by the Ministry of Health.

Albania's ratio of hospital beds to population is among the lowest in Europe. In 2000, there were 3.2 hospital beds per 1000 population, down from 4.0 beds in 1992. These bed numbers are among the lowest in CEE and the newly independent states (NIS) of the former Soviet Union, though several western European countries have even lower bed numbers, including Finland, Sweden and the United Kingdom. Many hospitals have closed down since 1992, while others have been converted into health centres. There are now 51 hospitals in the country, down from 160 in 1992.

Albania also has a low hospital admissions rate: 8.0 per 100 inhabitants in 1999, which is much lower than most other countries in the WHO European Region. Inability to make the often necessary under-the-table payments, poor quality of care, lack of drugs and unhygienic conditions discourage hospitalization even when it is necessary.

The average length of stay in 1992 was 12.7 days, and fell to 7.1 in 1999. Though this figure is low for a European Region country, it is by no means the lowest, especially with respect to western European countries.

Inpatient secondary care is provided mainly by district hospitals, which provide a minimum of four basic services: internal medicine, paediatrics, general surgery and obstetrics/ gynaecology. In 1992, the Ministry of Health decided to upgrade 6 to 12 district hospitals to regional hospitals that would each feature about 500 beds and provide a wider range of services. Work has begun on three of these hospitals, two subsidized by the World Bank and a third by the Organization of Petroleum Exporting Countries Fund for International Development (the OPEC Fund).

Patients needing tertiary care go to the 1500-bed University Hospital or other specialized hospitals in Tirana.

There in only one nongovernmental hospital, which is in the process of being built. The Catholic Church is investing in a 200-bed hospital in Tirana.

In recent years a number of private specialized outpatient services have appeared, mainly in urban areas.

Social care

Extended family ties are strong in Albania, so that relatives care for most dependent older people. There are few residential homes for the elderly, and no long-term elderly care hospitals.

One of the government's objectives is to care for the long-term mentally ill in the community and to reduce reliance on institutions. There are a few large psychiatric institutions for the long-term mentally ill, but the quality of care is very poor, and patients are isolated from their families. There are also some centres for people with learning disabilities, which are managed by some NGOs and the Ministry of Labour and Social Care.

Human resources and training

For the size of its population, Albania has few trained health care professionals in comparison to other European countries. Furthermore, health care professionals tend to be concentrated in hospitals. In 1999, the public health sector employed 25 676 people, a drop of 27% since 1991. In the same year, the private health sector employed 2954 professionals, or about 11.5% of the total, concentrated mainly in dentistry and pharmaceuticals distribution.

In 1999, Albania had 4494 doctors, or 1.36 doctors per 1000 population. Of these, 34% were PHC physicians. Albania and Turkey have the lowest population density of physicians in the entire European Region. The total number of nurses and midwives amounts to 3.7 or 4.0 per 1000 population, also one of the lowest rates in the European Region.

While the number of doctors per population has remained constant since 1994, nurse numbers have been declining – and the number of graduating doctors has been falling rapidly.

Doctors are trained at the Faculty of Medicine at the University of Tirana. Training of GPs began in 1997 with a two-year postgraduate course. There is no professional accreditation system for physicians, and no provisions for continuing medical education. In 1994 the first Faculty of Nursing was created in Vlora, and the School of Nurses in Tirana was upgraded to a College of Nursing.

Pharmaceuticals

The two Albanian state pharmaceutical companies, Profarma and the Antibiotics Factory, were privatized following their near collapse in 1992. There are additionally a few small pharmaceutical companies producing a limited range of drugs. Imports of pharmaceuticals have been increasing. All pharmaceuticals must be registered with the Ministry of Health before they can be sold in the country.

In 1994, an essential drugs list of 174 products was drawn up, adapted from the WHO Essential Drugs List; it was later expanded to 308 drugs. Only the pharmaceuticals on this list will be reimbursed, in part or in full, by the Health Insurance Institute. Drug reimbursement absorbed 70% of the Health Insurance Institute budget in 2000.

As funding is very limited, hospitals often run out of drugs before new supplies arrive, and then patients must buy their own drugs from private pharmacies. Private pharmacies are well stocked and better managed than hospital dispensaries. However, the absence of a good regulatory framework allows poor practices to continue, such as the dispensing of drugs that are of inferior quality, outdated or unregistered. The Ministry of Health recently established a body of pharmaceutical inspectors to make sure that drug distribution norms and regulations are respected.

Financial resource allocation

An annual budget is agreed upon and ratified by Parliament at the start of the financial year. Funds are then allocated to the Ministry of Health, local governments and other bodies. There is no real separation of purchasing from provision. In two pilot projects, the Health Insurance Institute is beginning to purchase services from the Durres Regional Hospital, and PHC services in Tirana.

A major shortcoming of the current system is the fragmentation of provider payments, particularly at the primary care level. It has been impossible to design an effective performance-based incentive system for PHC when the Health Insurance Institute sets the budget for GPs and pharmaceuticals, the Ministry of Health district offices set it for the rest of the staff, and local governments set it for operating expenditures.

Payment of hospitals and institutions

The Ministry of Health allocates funds directly to hospitals with a budget earmarked for staff salaries and other recurrent expenses. Hospital directors negotiate their budgets directly with the Ministry of Health and have only limited discretion over expenditure. Local governments are financially responsible for health centres and health posts, receiving the majority of their funds from the state.

The Health Insurance Institute is playing an increasing role in financing health care provision. It is now paying PHC doctors, and there is a major policy proposal to expand its role to funding all specialist care and eventually hospital inpatient care.

Payment of physicians

The Health Insurance Institute has paid the salaries of PHC physicians since 1995. Each salary is based on a capitation amount for the number of patients enrolled in a practice, with some weighting for geographic area and types of patients.

Other physicians' salaries are based on national pay scales. Many physicians also receive under-the-table payments from patients.

Remuneration for doctors is generally low and remains a major source of contention. However, it is said that PHC physicians paid by the Health Insurance Institute have increased their incomes by more than 50% since the establishment of the insurance system.

Health care reforms

The health care system that emerged after the collapse of the Communist régime has faced enormous difficulties, including severe budget constraints and the disruption and damage caused by civil disturbances, in an environment of political instability and extreme poverty. The reforms that have been undertaken can be grouped under four broad headings.

1. *Diversification of financing* has been made possible by a variety of measures, including the introduction of fees in the public sector and the establishment of the Health Insurance Institute. The introduction of private medical practice further diversified financing by shifting more of the financing burden onto consumers of health care.
2. *Decentralization* has granted some responsibilities to districts and local governments. The establishment of the Tirana Regional Health Authority furthered the decentralization process.
3. *The reform of health services* has included the transformation of many rural hospitals into health centres, the introduction of a compulsory registration process for physicians, the integration of five Tirana university hospitals under a single administration, the development of PHC and legislation addressing various public health issues.
4. *Drug distribution* has undergone significant change with the privatization of pharmacies, the introduction of a regulatory framework for the import and export of pharmaceuticals, and an obligatory drug registration system.

On the other hand, certain reforms have not been carried out successfully. The Ministry of Health did not create a regional map of district and regional hospitals; the regulatory framework for private health services has not been fully defined; postgraduate training in health management, public health and general practice are facing difficulties; health facility infrastructure and equipment remain substandard despite investments by the government and donors; and there is significant patient and provider dissatisfaction with the health care system.

Conclusions

Albania's health care system, like Albania itself, is facing huge challenges. The sustainability of its reforms rests on a flimsy foundation. The health care system is heavily dependent on humanitarian aid and money sent home by emigrants, and the ongoing brain drain is depleting the country of its most valuable human resources. Yet despite the difficulties, the basic infrastructure for health care delivery is being maintained and rationalized. The success or failure of the reforms will depend on the country's continued stability and its economic recovery.

Table 1. Inpatient utilization and performance in acute hospitals in the WHO European Region, 2001 or latest available year

Country	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
EU average	4.1[a]	18.9[b]	7.7[b]	77.4[c]
Albania	2.8[a]	–	–	–
Bosnia and Herzegovina	3.3[c]	7.2[c]	9.8[c]	62.6[b]
Bulgaria	–	14.8[e]	10.7[e]	64.1[e]
CEE average	5.4	17.8	8.3	72.3
The former Yugoslav Republic of Macedonia	3.4	8.2	8.0	53.7

Source: WHO Regional Office for Europe health for all database.
Notes: [a] 2000, [b] 1999, [c] 1998, [d] 1997, [e] 1996, [f] 1995, [g] 1994, [h] 1993, [i] 1992, [j] 1991.

European Observatory on Health Care Systems

HiT summary

Albania

The summary of the HiT profile on Albania was written by Ellie Tragakes. It was edited by Jeff Lazarus and copy-edited by Misha Hoekstra.

The full HiT profile on Albania, available at www.observatory.dk, was written by Besim Nuri (University of Montreal). Ellie Tragakes (European Observatory on Health Care Systems) served as editor, and Josep Figueras as research director.

The Observatory would like to thank the following people from Albanian ministries and institutes for their assistance: Silva Bino (Institute of Public Health (IPH)), Margarita Caci (Institute of Statistics (INSTAT)), Nurije Caushi (Ministry of Health), Eli Gjika (Ministry of Health), Saimir Kadiu (Ministry of Health and World Bank), Manuela Murthi (IPH) and Vigan Saliasi (Health Insurance Institute (HII)).

The Health Care Systems in Transition (HiT) profiles are country-based reports that provide an analytical description of each health care system and of reform initiatives in progress or under development. The HiTs are a key element that underpins the work of the European Observatory on Health Care Systems.

The Observatory is a unique undertaking that brings together the WHO Regional Office for Europe, the Governments of Greece, Norway and Spain, the European Investment Bank, the Open Society Institute, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine. This partnership supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of health care systems in Europe.