Health Care Systems in Transition

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Foreword

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

HiTs seek to provide relevant comparative information to support policy-makers and analysts in the development of health care systems in Europe. The HiT profiles are building blocks that can be used:

- to learn in detail about different approaches to the organization, financing and delivery of health services;
- to describe the process, content and implementation of health care reform programmes;
- to highlight challenges and areas that require more in-depth analysis; and
- to provide a tool for the dissemination of information on health care systems and the exchange of experiences of reform strategies between policy-makers and analysts in different countries.

The HiT profiles are produced by country experts in collaboration with the Observatory's research directors and staff. In order to facilitate comparisons between countries, the profiles are based on a template, which is revised periodically. The template provides the detailed guidelines and specific questions, definitions and examples needed to compile a HiT. This guidance is intended to be flexible to allow authors to take account of their national context.

Compiling the HiT profiles poses a number of methodological problems. In many countries, there is relatively little information available on the health care system and the impact of reforms. Due to the lack of a uniform data source,

quantitative data on health services are based on a number of different sources, including the WHO Regional Office for Europe health for all database, Organisation for Economic Cooperation and Development (OECD) Health Data and data from the World Bank. Data collection methods and definitions sometimes vary, but typically are consistent within each separate series.

The HiT profiles provide a source of descriptive information on health care systems. They can be used to inform policy-makers about experiences in other countries that may be relevant to their own national situation. They can also be used to inform comparative analysis of health care systems. This series is an ongoing initiative: material is updated at regular intervals. Comments and suggestions for the further development and improvement of the HiT profiles are most welcome and can be sent to observatory@who.dk. HiTs and HiT summaries are available on the Observatory's website at www.observatory.dk. A glossary of terms used in the HiTs can be found at www.euro.who.int/observatory/Glossary/Toppage.

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The current series of Health Care Systems in Transition profiles has been prepared by the research directors and staff of the European Observatory on Health Care Systems.

The European Observatory on Health Care Systems is a partnership between 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. The Observatory team working on the HiT profiles is led by Josep Figueras, Head of the Secretariat, and research directors Martin McKee, Elias Mossialos and Richard Saltman. Technical coordination is by Suszy Lessof.

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List of abbreviations

CEE	Central and eastern Europe
CCEE	Countries of central and eastern Europe
DFID	United Kingdom Department for International Development
GP	General practitioner
HII	Health Insurance Institute
INSTAT	Albanian Institute of Statistics
IOM	International Organization for Migration
IPH	Institute of Public Health
MCH	Maternal and child health
MoF	Ministry of Finance
NGO	Nongovernmental organization
NIS	Newly independent states
PHC	Primary health care
SII	Social Insurance Institute
TRHA	Tirana Regional Health Authority
UNDP	United National Development Program
WHO	World Health Organization

Introduction and historical background

Introductory overview

Albania is located in south-eastern Europe on the Balkan peninsula, bordered by the Federal Republic of Yugoslavia in the north, the former Yugoslav Republic of Macedonia in the east and Greece in the south. To the west are the Adriatic and Ionian seas. The country covers an area of 28 750 km^2 and is primarily mountainous, apart from its flat coastline.

Albania's population is younger than that of other European countries. A third of its 3.1 million inhabitants is under the age of 15, and 40% is younger than 18. The population grew by 1.2% per year in the period 1980–1999, with a fertility rate in 1999 of 2.4 children per woman of childbearing age *(1,2)*. The country experienced even higher population growth in earlier decades, encouraged by the pronatalist policy of the Communist regime.

A high proportion of Albania's population lives in rural areas, amounting to 58% in 2001 *(3)*[1]. However, since restrictions on freedom of movement were lifted in the 1990s, there has been a level of internal migration from rural to urban areas that is unprecedented in Albania. In 1979, only 33.5% of the population was urban. This figure rose to 35.5% in 1989, and in 2001 it reached 42.1%. Due to this influx, the population in the district of Tirana has increased

[1] In Albania, the information systems at all levels face enormous problems in collecting and processing data. The Institute of Statistics (INSTAT) acknowledges in its Demographic yearbook 1990–1999, that "during 1992–1999, the information on the total number of demographic events as well as on their structure by sex, age groups, place of residence, etc., is not complete" (*4*). In addition, the absence of a population census during these years makes the Albanian population figure just an estimate, one that may in fact be highly inaccurate. External and internal migration, as well as other important demographic phenomena, have not been taken carefully into account. Therefore, many indicators may be distorted. The preliminary results of the 2001 census show a decrease in the Albanian population, from the INSTAT estimate of 3.4 million people to 3.08 million people (3).

Fig. 1. Map of Albania[2]

Source: United Nations Cartographic Section.

[2] The maps presented in this document do not imply the expression of any opinion whatsoever on the part of the Secretariat of the European Observatory on Health Care Systems or its partners concerning the legal status of any country, territory, city or area or of its authorities or concerning the delimitations of its frontiers or boundaries.

rapidly to more than 500 000, which has put considerable strain on its infrastructure and health services *(3)*.

Many people have also left the country – over 750 000 between 1990 and 1999 *(5)*. It appears that this emigration process has not slowed yet, and Albanians are still leaving, both legally and illegally. Thus, according to the last census, the population of Albania decreased slightly in the period 1989–2001 *(3)*. Bearing in mind the country's high fertility and population growth rates, this development can only be explained by extensive emigration. Another major population shift occurred in early 1999 when more than 700 000 people fled Kosovo (or Kosova), and over 400 000 of them sought refuge in Albania.

About 97% of the Albanian population is ethnic Albanian and 1.9% Greek, while other groups are represented in small numbers. A unified form of the Albanian language has been used since the early 1970s. Islam is the religion of 70% of the population, while 20% are Orthodox Christian and 10% Roman Catholic *(6)*. These figures reflect "the religion of origin", since religion has not been an important identifying element in Albanian society. However, with the return of religious freedom, many mosques and churches that were closed in 1967 have now reopened.

Table 1. Demographic indicators

	1994	1995	1996	1997	1998	1999	2000	2001
Population (millions)[a]	3.202	3.248	3.283	3.324	3.354	3.373	3.401	3.087[b]
Percentage under age 15[a]	33.4	33.0	33.0	32.9	32.6	32.4	32.2	–
Live births per 1000[a]	22.5	22.1	20.8	18.5	17.9	17.1	–	–
Deaths per 1000[a]	5.73	5.56	5.36	5.49	5.44	4.96	–	–
Ratio of births to deaths[a]	4.02	3.99	3.88	3.38	3.29	3.46	–	–

Sources: [a] *INSTAT, 2000;* [b] *INSTAT,* Population census*, 2001.*

The ancestors of the Albanians, the Illyrians, preserved their own language and culture despite the establishment of Greek colonies in the 7th century BC and subsequent centuries of Roman rule. Illyria became part of the Byzantine Empire in the division of 395 AD. Migrating Slavic and Germanic groups invaded the region throughout the 5th and 6th centuries. Various neighbours contested control of the region, and in 1344 the country was annexed by Serbia, which in turn was occupied by the Turks in 1389. A national Albanian hero, Skenderbeg, led the resistance opposing the Ottomans. In 1479, Albania was finally incorporated into the Ottoman Empire, in which it remained a very poor rural province for several centuries.

Albania achieved independence from the Ottoman Empire in 1912. Kosovo (nearly half of Albania) was transferred to Serbia at the 1913 peace conference.

Albania was overrun by successive armies in the First World War and became a kingdom only in 1928, under King Zog I. Italy occupied the country during the Second World War, and King Zog fled to the United Kingdom. The Albanian Communist Party, founded by Enver Hoxha, led the resistance against first the Italians and then the Germans.

A provisional government was formed in 1944. In January 1946, the People's Republic of Albania was proclaimed, and the Communist Party was renamed the Labour Party. Hoxha became president and remained in power until his death in 1985. Albania initially followed Soviet-style economic policies, but in 1961 it broke off diplomatic relations with the Soviet Union and aligned itself with China until 1978. It remained a Communist state from 1944 until 1991, pursuing a policy of independence while negotiating a series of foreign loans from first Yugoslavia, then the Soviet Union and finally China. Albania's isolation from the rest of the world and lack of export earnings contributed to its slow development and sustained poverty.

In the early 1990s, after Communism collapsed in eastern Europe and the Albanian population staged demonstrations, the government agreed to allow opposition parties. The governing Labour Party (later renamed the Socialist Party), led by Ramiz Alia, won re-election in March 1991 after promising the privatization of state land. The Democratic Party, led by Sali Berisha, won the election in March 1992. The parliament then elected Berisha President for a five-year term from April 1992 to March 1997.

March 1997 saw the collapse of several pyramid savings schemes, in which perhaps two thirds of the population had invested money, with an estimated loss of US $1000 million *(7)*. People blamed the government for complicity in the schemes, and widespread violence followed. It was particularly bad in the south of the country, and many communes and municipalities ceased to function. The country's economic growth rate of the previous four years was reversed; inflation and unemployment rose and economic recovery was interrupted.

In the wake of this scandal, the recently re-elected Berisha was forced to call new parliamentary elections in June 1997. He resigned the presidency when the Socialist Party won, and his successor named Fatos Nano prime minister. In September 1998, the assassination of the deputy head of the Democratic Party provoked demonstrations, and clashes ensued between the followers of Sali Berisha, now the opposition leader, and the government. The prime minister's offices were ransacked. The rioters had access to guns and other weapons looted from government armament stores the previous year. Nano resigned and a new prime minister, Pandeli Majko, was appointed in late September 1998.

The elections of June 2001 were carried out peacefully, and despite the turmoil of the previous four years, the Socialist Party again won the majority of votes. Ilir Meta became the new prime minister. However, the Democratic Party, headed by Berisha, did not recognize the legitimacy of these elections and refused to send its elected deputies to the parliament for some time. Internal tensions in the Socialist Party forced a reconfiguration of the government, and Fatos Nano became prime minister again in July 2002. The agreement between the Democratic and Socialist parties in June 2002, known as the Berisha–Nano agreement, was a major political achievement for Albania, and it led to the parliament's peaceful election of Alfred Moisiu as president in June 2002.

The 1976 constitution of Albania was abolished in 1991 and replaced with interim constitutional provisions. A new constitution was adopted on 28 November 1998, following majority approval in a referendum held on 22 November. Under the new constitution, executive power rests with the president, who has a 5-year mandate. The president appoints the prime minister and the Council of Ministers, which has 22 ministers under the present government. The parliament is a unicameral legislature of 140 members, of whom 100 are elected directly and 40 come from party lists. The first such parliament was elected in July 2001 and includes a number of political parties.

Since 1993, Albania has been divided into 12 administrative areas called prefectures, each with a centrally appointed administration. The district had been the key administrative division in Albania for the previous 50 years. During Communist rule, Albania was divided into 26 districts, with administration under the control of the communist party. In 1992, the number of districts was increased to 36. In 1993, districts were further divided into rural areas (communes) with elected local authorities, and into municipalities with elected councils. Also in 1993, the concept and practice of prefectures was introduced, with an average of three districts forming one prefecture, each administration being centrally appointed.

Each district has at least one municipality and a number of communes. For example, the Tirana district covers 1 urban municipality, 3 semi-urban municipalities and 15 rural communes, each of them with locally elected authorities. There are 315 communes and 42 municipalities in the country. Although in theory they all have tax-raising powers, in practice local governments receive almost all their annual revenue from the central government.

The economy and population health

Albania is one of the poorest countries in Europe. The presence of an extensive informal economy causes serious difficulties in calculating gross domestic

product (GDP) and gross national product (GNP). According to the most reliable estimates GNP per capita was US $930 in 1999 *(1).* GDP per capita, adjusted for purchasing power parity (PPP), was estimated at US $2892 in 1999 *(1).* While the economy is slowly recovering after the financial crisis and the tragic events of 1997–1999, per capita GDP remains low for the region, as revealed by a comparison with the 1999 figures for the former Yugoslav Republic of Macedonia (US $PPP 4590) and Bulgaria (US $PPP 5070) *(1).* Agriculture and forestry are the main sources of employment and income in Albania, but in recent years, the construction, transport and service sectors have been growing. Money sent home by emigrants forms another important part of the economy, reaching about US $500 million in 1999, or approximately a fifth of the GDP *(5).*

After the collapse of the centrally planned economy in 1991–1992, the country began a transition to a more open economy. The economy grew strongly between 1993 and 1996 as the government managed to control inflation and embarked on widespread privatization. However, the riots in 1997 and again in 1998 were major setbacks to political and economic stability. The wars in Bosnia, Kosovo and the former Yugoslav Republic of Macedonia also had a negative effect on Albania's economy during the 1990s, as did United Nations sanctions against Yugoslavia and Greek sanctions against its Macedonian neighbour. GDP fell again in 1997 after four years of growth (see Table 2). Government expenditure as a percentage of GDP also dropped dramatically, from 62% in 1990 to 26% in 1999, with consequent constraints on government services *(8).* The political stability of recent years, however, has allowed some economic growth and recovery.

Registered unemployment fell in 1994 and 1995 as the economy improved, but since then, real unemployment has risen substantially. The registered unemployment rate increased from 12.3% in 1996 to 18.3% in 1999 *(5),* but these figures underestimate true unemployment.

Despite widespread poverty during the Communist regime, poverty was not officially acknowledged until the 1990s. According to surveys and official statistics, 29.6% of Albanians are poor, with half of this group in the category of extreme poverty. In addition, one in three families has shelter-related problems; 14% of the children under age 5 are undernourished; illiteracy has increased (only 88% of the population under age 15 can read and write); and 75% of the families who are poor also suffer from acute social problems *(9).*

In 2001, the Albanian government developed a medium-term programme in collaboration with a number of international partners, including the World Bank, the International Monetary Fund (IMF), UNICEF and UNDP. *Growth and poverty reduction strategy 2001–2004* addresses the acute problems arising

Table 2. Macroeconomic indicators

	1991	1992	1993	1994	1995	1996	1997	1998	1999
Real GDP growth rate (% change)	–27.7[a]	–7.2[a]	9.6[a]	9.4[a]	8.9[a]	8.2[a]	–15.0[a]	8.0[b]	8.0[b]
Annual inflation rate (%)[a]	35	226	85	22	8	13	32	20	2
GNP per capita (US $)[c]	–	–	340	380	–	–	750	810	870
GNP per capita (US $PPP)[c]	–	–	–	–	–	–	–	–	2 892
Government expenditure as % of GDP	61.9[a]	43.9[a]	40.2[a]	36.3[a]	34.3[a]	28.1[d]	24[d]	23[d]	25.8[d]
Registered unemployment rate	9.0[a]	27.0[a]	22.0[a]	18.0[a]	12.9[e]	12.3[e]	14.9[e]	17.7[e]	18.3[e]

Sources: [a] United Nations Children's Fund (UNICEF) Innocenti Research Centre (IRC), *TransMONEE database 2000*, 2000; [b] World Bank, *Country assistance strategy*, 2000; [c] World Bank, *World development report(s);* [d] Albanian Ministry of Finance (MoF), 2000; [e] United Nations Development Program (UNDP), *Albania 2000,* 2000.

in the course of development, with a particular focus on poverty reduction through sustainable economic growth *(9)*.

With its high birth rate falling, Albania is in the midst of a demographic transition. It has high rates of infant and maternal mortality. The prevalence of infectious diseases continues to be high, while that of chronic illnesses, such as cardiovascular disease (the leading cause of death), is rising *(10)*.

However, the Albanian population enjoys a reasonably long life expectancy, which seems paradoxical when one takes into consideration the country's low incomes, very limited health services and frequent outbreaks of infectious diseases. During the period 1990–1995, life expectancy was 68.5 years for men and 74.3 for women *(4)*. This figure was only slightly below the average for western Europe, and above the average for CEE. However, these figures are declining, with one year of life expectancy lost in the period 1990–1995. Albania illustrates the link between healthier lifestyles and better health, not only by comparison to other countries, but also within the country itself, with better health indicators in the south than the north, a pattern that reflects dietary variation *(11)*. The population has good nutrition with a traditional diet high in fruit and vegetables. The country also reports comparatively low levels of alcohol and tobacco use, though they are said to be rising. Cigarette smuggling in Albania has increased, which makes it difficult to estimate cigarette consumption accurately.

According to figures published by the Ministry of Health, infant mortality dropped to 17.5 deaths per 1000 live births in 1999 *(12)*. However, these figures are not convincing when one considers the economic situation of the country and the accessibility and quality of its health services. According to UNICEF calculations, which were made using QFIVE (a United Nations computer program for estimating child mortality), infant mortality in Albania was 28 per

1000 live births in the year 2000 *(13)*. The infant mortality rate remains one of the highest in the region and in Europe (see Table 5).

According to INSTAT, in 1999, 40% of infant deaths occurred in the early neonatal period, suggesting that maternity services offer poor quality of care for newborn babies. An important cause of infant deaths is respiratory infections, accounting for 27% of cases. In some rural areas, the infant mortality rate is twice as high as in urban areas. The mortality rate for children under five is reported to be 33 per 1000 live births for the year 2000 *(13)*. Statistics on life expectancy and infant mortality were manipulated during the Communist regime, making it very difficult to make comparisons with pre-1991 data.

A number of vaccine-preventable diseases are still common in Albania. In 1999, there were 797 cases of measles *(14)* and about 700 new cases of tuberculosis *(12)*. Mortality rates for infectious, parasitic and respiratory diseases are high for infants and young people. There was a severe cholera epidemic in 1994 and a poliomyelitis outbreak in 1996. There are also high rates of pulmonary tuberculosis and hepatitis as well as epizootic diseases, which reflect in part unhygienic living conditions and poor sterilization procedures. The morbidity picture is not very clear, however, since statistics are collected mainly from hospital admissions.

Table 3. Health indicators

	1990	1995	1996	1997	1998	1999	2000
Female life expectancy at birth (years)[b]	75.4	74.3	–	–	–	–	–
Male life expectancy at birth (years)[b]	69.3	68.5	–	–	–	–	–
Infant mortality rate (per 1000 live births)[a]	33.2[a]	34[a]	25.8[a]	22.5[a]	20.5[a]	17.5[a]	28[c]
Under 5 mortality rate (per 1000 under 5)[a]	49.7	37	30.6	–	–	–	33[c]
Maternal mortality (per 100 000 live births)[b]	28.0	28.5	24.8	27.5	21.6	17.5[b]	–
Abortions (per 100 live births)[b]	–	44.2	47.6	35.8	31.5	34.4	–

Source: [a] UNICEF IRC, 2000; [b] INSTAT, Demographic indicators, 2000; [c] UNICEF – Albania, 2000.

Maternal mortality, at over 21 per 100 000 live births in 1998, is still high in comparison to western Europe, but it has improved since the early 1990s due to the introduction of a new reproductive health (RH) policy. Compared to other Balkan countries, Albanian maternal mortality remains higher than in Bulgaria and the former Yugoslav Republic of Macedonia, but lower than in Romania and Turkey (Table 5). Poor prenatal care may account for some of this high rate, as may deaths from abortions. Abortion was illegal before 1992,

and rates increased dramatically during the period 1992–1997 with over 40 abortions for every 100 live births. However, in recent years the abortion rate has decreased, which could be explained two ways: (i) family planning services have become accessible to more women, and/or (ii) private clinics, which are growing in number, do not report all abortions. Yet despite the lower rate in recent years, health services still do not offer all women family planning that includes alternative methods of birth control.

Table 4. Major causes of death

	Deaths per 100 000					
	1994	1995	1996	1997	1998	1999
Cancers	56.6	66.9	75.7	69.4	73.4	76.0
Nervous system and sense organ diseases	19.7	15.0	15.4	11.6	13.4	8.8
Circulatory system diseases	171.5	206.8	224.4	202.3	222.1	205.0
Respiratory system diseases	62.2	61.9	55.2	40.8	38.8	31.0
Digestive system diseases	15.7	16.6	14.6	11.4	11.2	10.0
Genito-urinary system diseases	6.5	9.9	8.0	8.0	7.8	7.4
Senility and ill-defined conditions	66.3	44.2	44.5	36.1	42.7	40.0
Accidents and injuries	32.5	44.0	44.0	82.7	58.0	51.0

Source: INSTAT.

The death rate in Albania is about 5 per 1000, and this indicator appears not to have changed significantly during the last ten years. There are, however, changes in the structure of the mortality causes. According to INSTAT, the mortality data for 1999 show that 45% of all deaths in Albania were caused by circulatory system diseases, 16.6% by cancer and 11% by accidents and injuries. These three groups of diseases cause three quarters of all deaths. Deaths from cardio-circulatory diseases increased from 36.6% in 1994 to 45% in 1999, and a similar increase held true for cancer. Moreover, the share of accidents and injuries increased dramatically, having almost doubled their share of the mortality structure, causing 11.8% of all deaths in 1998, compared to 6.9% in 1994 *(15,16)*.

Table 5 places Albania in a regional perspective by summarizing some economic and health indicators for five Balkan countries. It demonstrates that health expenditure and average income are not the only determinants of health. Albania is decidedly the poorest country in the region, but some of its health indicators are better than those of its wealthier neighbours: life expectancy in Albania is greater than in Bulgaria, Romania and Turkey, while its crude death rate is the lowest of the group. However, its infant mortality rate remains one of the highest in the region, exceeded only by Turkey's.

Table 5. Economic and health indicators for five Balkan countries

	GDP per capita (US $) 1999	GNP per capita (US $PPP) 1999	Life expectancy at birth (years) 1999	Crude deaths rates (per 1000 population) 1999	Infant mortality (per 1000 live births)	Maternal mortality (per 100 000 live births) 1995 adjusted	Total health expenditure (% of GDP) 1990–1998 (most recent year available)
Albania	930	3 240	72	5	24	31	4.0
Bulgaria	1 410	5 070	71	14	14	23	4.7
Romania	1 470	5 970	69	12	20	60	4.1
The former Yugoslav Republic of Macedonia	1 660	4 590	73	8	15	17	6.5
Turkey	2 900	6 440	69	6	36	55	5.8

Sources: World Bank, World development indicators, 2001.

Historical background

Before the Second World War, Albania had few doctors, most of whom had trained abroad, and a small number of private hospitals and institutions run by religious groups. In 1932, for instance, there were 111 medical doctors, 39 dentists, 85 pharmacists and 24 midwives in the country *(17).* Most of the population did not have access to health care facilities, which were mainly based in urban areas. Access improved after 1945 when a health care system was developed based on the Soviet "Semashko" model. The first medical school opened in Tirana in 1959. Many medical experts also trained in the Soviet Union and other eastern European countries.

Despite the country's break with the Soviet Union in later years, many aspects of health care policy and planning in Albania continued to follow the Semashko model. Sanitary-epidemiology centres were set up in each of the 26 districts. During the 1960s, an extensive primary health care (PHC) system was developed, providing every village with at least a midwife responsible for antenatal care and immunizations. However, in the 1970s the emphasis switched to hospital care. Hospitals were constructed in every district to provide basic inpatient care, with polyclinics for specialist outpatient care.

By the 1980s, the Ministry of Health provided and regulated all health services in every district. District administrators received instructions from

the district executive committee of the Labour Party, and had very limited power in terms of budget utilization and personnel management. Health services were organized in programmes controlled from the centre and administered at the district level by separate directorates responsible for medical care. They included directorates for hospitals, for specialized outpatient polyclinics and PHC centres, for hygiene and epidemiology, for dentistry and for pharmaceuticals. The Ministry of Health itself ran the clinical hospitals providing tertiary care.

The Ministry of Health also appointed the directors of health care institutions, primarily doctors who simply implemented the instructions of their superiors. They had little discretion to improve services, for instance through reallocating staff. The Ministry of Health could not control their day-to-day activities, however, except to fire them if they broke the rules. The system had no management training, no procedural guidelines, no performance indicators or incentives, and little research and development. The Ministry of Health and the Communist regime regarded some health indicators as extremely important. For example, realizing that infant mortality is considered a good indicator of a country's socioeconomic conditions, the Communist authorities made its reduction a priority. However, in the early 1990s, this indicator was still high in comparison to the rest of Europe, indicating widespread poverty, malnutrition and poor health services.

There was some duplication of medical care, with the same kinds of specialists working in hospitals, health centres and occupational health services. The military had their own health care facilities, including a specialized hospital in Tirana, and there were health centres for employees in some industries. However, the parallel health care systems typical of some Communist countries did not exist in Albania to the same degree.

The quality of services was poor, there was little continuing medical education, and hospitals were kept overstaffed by keeping salaries low. The level of medical technology was also very low and the equipment outdated because capital investment in the health care system had dropped in the 1980s. Thus, at the beginning of the 1990s, the average age of medical equipment in Albania was 25 years *(18).* The continuing high rates of infant mortality and the outbreaks of infectious diseases in the 1980s highlighted the inability of the system to respond effectively to health care problems.

The effect of civil conflict and crisis on the health system

Since the collapse of the Communist regime, government services, including health care, have suffered several additional setbacks. During the political

changes in 1991 and 1992 and the violence that accompanied it, almost a quarter of the city health centres and two thirds of the village health posts were destroyed *(19)*.

Along with the destruction of some district hospitals, health centres and public health departments, the violence in early 1997 also involved widespread looting of drugs and equipment. Most hospitals were reduced to providing emergency care only, and about 30% of the country's medical staff abandoned their posts, with higher rates in the south. Immunization programmes were seriously disrupted by the breakdown of refrigeration and vaccine transport. Disease surveillance, water purification and human waste disposal were also interrupted *(7)*. In addition, the financial crisis left some hospitals unable to pay their employees' salaries for as long as two months.

The civil unrest revealed ongoing administrative and communicational weaknesses in the health system's ability to respond to crisis. It is unclear whether the attacks upon health services were just part of the population's generalized anger towards the government, or whether they also indicated serious dissatisfaction with the health sector. Although it had not resumed full functioning, Albania's health care system was just beginning to recover when factional fighting broke out in late 1998.

Meanwhile, the situation in the neighbouring Serbian province of Kosovo, which had long been volatile, came to a head. War broke out in 1998 when ethnic Albanians, who made up 90% of the province's 1.8 million inhabitants, sought independence from Serbian rule. NATO intervened in March 1999 to force the withdrawal of Serbian forces and to secure the safety of internally displaced ethnic Albanians within Kosovo. It failed to accomplish the latter. By late April 1999, over 700 000 ethnic Albanians had fled from Kosovo to the neighbouring countries of Montenegro, the former Yugoslav Republic of Macedonia, and Albania, which struggled to cope with the massive humanitarian disaster. In late June 1999, after Yugoslavia agreed to a peace plan put forward by the Group of 8 (G8) and backed by the United Nations, the refugees began to return to Kosovo.

The health system of Albania faced enormous challenges during the Kosovo crisis. First, many refugees arrived exhausted, undernourished and ill. For example, during April 1999, about 4000 refugees were admitted to hospitals, about half of them children aged 5 and under. Second, public hospitals were used as shelters, with refugees occupying about 30% of the country's hospital beds at the height of the crisis. Third, field hospitals were set up by NATO and relief organizations. The five NATO hospitals were used not only by military personnel and refugees but also by native Albanians. The result was a shift in the utilization of hospital services within the country *(20)*.

The Albanian health system successfully coped with the Kosovo refugee crisis through an extraordinary effort and the significant support of international humanitarian agencies. However, the crisis caused further damage to its already weak infrastructure, absorbed resources and imposed delays on an already difficult reform process. On the other hand, the crisis brought many new health care donors into Albania. By June 2000, health care crisis relief amounted to approximately US $160 million *(21)*.

Organizational structure and management

Organizational structure of the health care system

The basic structure of public administration in Albania has continued largely unchanged in the 1990s since the advent of multiparty democracy, as has the structure of the health sector. However, two public administration reforms have affected health services. First, after the 12 regional prefectures were created in 1993, some administrative authority has shifted to them from the centre. Each prefecture comprises an average of three districts, and each district is responsible for administering district hospitals and polyclinics, specialist hospitals (such as tuberculosis hospitals) and PHC centres. The second reform was aimed at strengthening the role of local government. The 1993 law *On Local Government* regulated the election of local authorities and their responsibilities, functioning and relationships to the national government. In the area of health care, the law also shifted some responsibility for PHC to rural areas.

The government has not yet finalized a comprehensive health sector strategy, despite encouragement from various international organizations, primarily WHO. However, it has recently published some key strategy proposals in *Albanian health system reform – a position paper on policy and strategies for Albanian health system reform (22)*, as well as in *Medium-term expenditure framework: 2001–2003 (8).*

One of the proposals is to change the role of the Ministry of Health from a management body to a policy-making body, one that is able to:

1. formulate health policies and strategies
2. prepare guidelines for accreditation and quality control
3. regulate private sector activities

4. lead intersectoral work and coordinate donor activities
5. develop a strong centre in tandem with the carefully planned decentralization of local planning and management functions.

With assistance from the United Kingdom Department for International Development (DFID) and the World Bank, a regional health authority was set up and has begun operating in the Tirana Prefecture.

Another proposal is to redraw the institutional map of the public health care sector through an organizational and functional reshaping of its central institutions. Such restructuring would require strengthening their capacities in order to make them able to assume new functions and responsibilities. The institutions would acquire more autonomy in the control of their resources. Secondary care services would be restructured through the introduction of regional hospitals, which would offer specialized services according to local population needs. The government recognizes that strengthened hospital management capacity is a fundamental condition for the success of the proposed measures.

Finally, the strategy documents also prioritize human resource development. The government is committed to developing a system of integrated health services, with an emphasis on primary care provided by general practitioners (GPs) and community nurses, and on further training and retraining for hospital staff. It also regards the introduction of professional managers as essential.

Ministry of Finance (MoF)

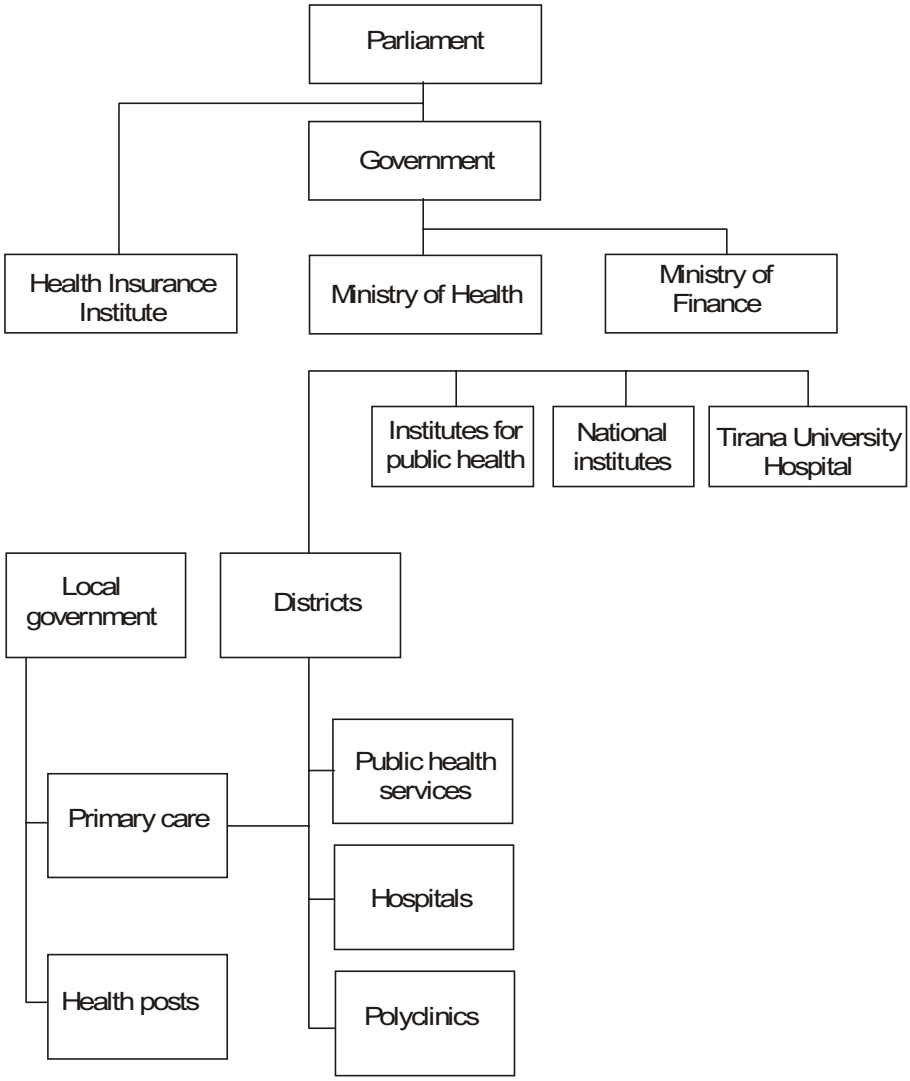
The MoF allocates money to the other ministries, including the Ministry of Health, and provides local governments with earmarked funds. It also transfers to the HII the basic service and essential drug subsidies available to some of the more unprotected and vulnerable segments of society, including retired people, children and students.

Ministry of Health

The Ministry of Health remains the major funder and provider of health care services in Albania. The ministry has been reorganized, and it continues to assume the lead role in most areas of health care. It "owns" most health services, with the partial exception of primary care.

The Ministry of Health devotes most of its efforts to health care administration, rather than policy and planning. Many health care institutions (especially in tertiary care) are under the direct administrative control of the Ministry of Health and its small and overworked staff, which makes it difficult for these organizations, and for the administrative districts, to make quick

Fig. 2. Organizational chart of the health care system



decisions. The need to administer foreign aid has added to this burden. In addition, the growing private sector is inadequately regulated.

It was with these difficulties in mind that the Ministry of Health initiated a careful restructuring process, in order to shift gradually into more of a national policy-making and planning role. As an important step, it created a new Policy and Planning Department in November 2000 with a twofold objective.

- *To develop Ministry of Health capacity for making and planning health policy.* The department will start developing a short- and a medium-term plan to strengthen the ongoing process of restructuring and rehabilitating the health care system. The goal is to develop a more effective system that is better attuned to the needs of Albanian citizens.
- *To develop rapidly the Ministry of Health capacity for making better use of donor interventions in accordance with the short- and medium-term strategies.* In addition, the Ministry of Health needs to become better at handling the daily issues involved in administering the aid of donor agencies and nongovernmental organizations (NGOs) according to agreed plans, so as to make optimal use of their input in addressing the most pressing needs of the Albanian health care system.

The Policy and Planning Department has begun to carry out some of its scheduled activities, but it lacks the management tools and experience to undertake major planning activities. It should be noted that it is a small unit that can facilitate the planning process, but large planning efforts need to be undertaken by the main stakeholders in the system (hospital managers, PHC managers, etc.).

District directorates and the Tirana Regional Health Authority (TRHA)

Health directorates used to be organized around separate vertically integrated services, such as maternal and child health (MCH), but they have been replaced with a hospital directorate and a PHC directorate. The directorates are administered primarily through the Ministry of Health district bureaucracy. Following a government decree of July 2000, a new model was introduced in the Tirana Prefecture (which includes two districts) with the assistance of DFID and the World Bank. Primary care services and public health programmes have been integrated under the TRHA, a single organization that is responsible for their planning and management. A regional health board has been set up and is responsible for endorsing proposed regional policies, plans and budgets. It is hoped this model will pave the way for the Ministry of Health to delegate more authority and power to regional bodies.

However, the implementation of this model faces many challenges and difficulties. Despite the Ministry of Health's initial support, at least in principle, for the idea of devolving some of its powers to the TRHA, in practice it still shows signs of resistance and hesitation. The staff of the TRHA has not been adequately trained and cannot perform required tasks. Another major problem is that the respective roles of the TRHA and the HII in financing PHC are not clearly understood. While there is always a natural tension between payer and provider, the management system and business procedures have not been articulated in detail. Such shortcomings in implementation have contributed to the tension and resistance. The overpoliticized environment in Albania makes it very difficult for stakeholders to reach a consensus. It is hoped that the problems will be worked out in the course of implementation.

Another concern with respect to the TRHA involves its public health functions; that is, activities other than the provision of health care. The health authority has inherited the Public Health Department from the old Tirana Directorate, and there does not seem to be an adequate strategy in place for modernizing its functions. There also should be better information flow between the health authority and the IPH (see below), as well as consensus on standards for public health programmes.

The Institute of Public Health (IPH)

Under the Ministry of Health, the IPH is responsible for health protection (particularly the prevention and control of infectious diseases and the national vaccination programme), environmental health and the monitoring of drinking-water and air quality. It works mainly through the district public health services. Monitoring of food quality is a responsibility that the Ministry of Agriculture and the Ministry of Health share.

In 2000, the IPH merged with the former National Directorate of Health Education and Promotion, and it now coordinates the directorate's former functions.

The Ministry of Environmental Protection, created in September 2001, currently performs the function of environmental protection, which was previously performed by the National Environment Agency.

Health Insurance Institute (HII)

Another major health system change was the introduction of social health insurance in 1995. The HII is a national statutory fund, which in 1996 was granted autonomy as a quasi-governmental body accountable to the parliament. Coverage is being extended cautiously in a series of planned stages. Individual

contributions to the national fund are, in principle, compulsory, and nearly 70% of the population was covered by 1997. Until recently, the HII was financially responsible for only the salaries of PHC doctors and essential pharmaceuticals.

In 2000, the HII initiated two pilot initiatives:

- funding all PHC expenditures in the Tirana Prefecture, including salaries of not only doctors but also nurses and other personnel, as well as the recurrent costs for these services;
- funding the Durres Regional Hospital.

These pilot initiatives are part of the government's strategy to extend health insurance coverage. Despite some resistance, the HII is on its way to becoming the primary purchaser of health care services in Albania.

Local governments

The local government authorities of all 315 rural communes now own their PHC facilities and are thus partly responsible for PHC. The MoF gives them grants earmarked for equipping, maintaining, operating and upgrading PHC centres and posts, as well as for paying some staff salaries. In urban areas, Ministry of Health district offices still own and administer such services.

Private sector

Private health services reappeared in Albania in the beginning of the 1990s, following the collapse of the Communist regime. New legislation and the reform of the health sector paved the way for the development of various types of private services and facilities. Today the private sector provides the following important health services.

- *Drug distribution*. Most of the drug distribution system in Albania is private. A dozen wholesale companies import most of the drugs, biological products and diagnostic equipment in the country. A network of about 750 private pharmacies and pharmaceutical agencies ensure a good distribution of drugs all around the country, including rural areas. The establishment of the health insurance scheme and the subsidizing of essential drugs have strengthened the development of the private drug distribution network.
- *Dentistry services*. Dental care is private, with the exception of emergency dental services and services provided in school to children up to age 18. Both of these public services are free.
- *Medical care*. Private medical care has been developing rapidly, despite the country's difficult economic situation. Most private services are provided

in diagnostic centres and specialized outpatient clinics and located in large urban areas, particularly Tirana. Albanian legislation does not allow doctors employed in the public sector to practice medicine privately, except for professors from the Faculty of Medicine at the University of Tirana. However, the rapid expansion of the private sector makes it more likely that some public doctors are moonlighting.

There are no private hospitals or inpatient facilities yet in Albania.

Most private sector facilities are well equipped and organized. Some of these health services are financed and organized by foreign NGOs, private agencies or religious bodies such as the Roman Catholic Church or the Christian Orthodox Church. However, there are no mechanisms in place to monitor the quality of services offered by private facilities. In addition, there is no exchange of information between private and public facilities.

Voluntary organizations

Nongovernmental organizations (NGOs) are a new phenomenon in Albanian society, one that has developed in the last ten years. Under the Communist regime, such organizations were not allowed, and all activities were under the strict control of the Labour Party. During the crises of 1991–1992, 1997 and 1999, the many foreign NGOs active in the country encouraged and supported the development of Albanian civil society. Albanians participated in humanitarian activities through their local NGOs during the most difficult situations, especially during the Kosovo refugee crisis of 1999, when local NGOs succeeded in mobilizing more quickly than governmental bodies and the United Nations High Commissioner for Refugees (UNHCR) *(5)*.

There are many active NGOs and professional associations in the Albanian health sector. Some of them are very large and well organized, such as the Albanian Red Cross, an organization that has branches and volunteers in every district of the country. Others are more modest and operate in limited geographic areas. Most NGO financing originates from foreign bilateral and multilateral agencies. Many of the health sector NGOs are members of a large umbrella organization set up for the purpose of information exchange and coordination.

The health professions are served by professional associations such as the Order of Physicians, the Nurses' Association, the Dentists' Association, the Family Doctor Association, etc. These organizations focus mainly on the protection of their members' rights and professional development, but they lack the experience and resources to allow them to structure their activities better.

Planning, regulation and management

Planning

The formulation and development of policies and plans in the Albanian health sector have been affected by two important factors. First, several consecutive crises (financial, social, political and regional) have had a significant impact on health services, forcing the Ministry of Health to adopt a more reactive approach in order to cope with the dramatic events of recent years. Second, the weak technical capacities of the Ministry of Health leadership team have made it extremely difficult to formulate policies and plans for the health care sector. Despite these difficulties, the policy-making and planning process has slowly advanced, helped along by a substantial amount of external assistance and driven mainly by bi- and multilateral agencies.

In 1993, the Ministry of Health produced *A new policy for the health care sector in Albania*. In 1996, in cooperation with WHO, it produced a draft document setting out medium-term policy objectives. The financial crisis and change of government in 1997 interrupted the planning process. However, the Ministry of Health did produce some subsector plans with the support of international experts. The plans included a PHC policy, which was developed with help from the European Union (EU) Phare programme (1997) *(23);* plans for the development of Vlora and Shkodra regional hospitals (1997); a strategy for the Tirana regional health system, produced with the assistance of the World Bank (1997); and a master plan for the development of the Tirana University Hospital Centre, prepared with the help of the Assistance Publique des Hôpitaux de Paris (1997) *(24)*. There was a widespread recognition of the need to integrate these and other plans under the framework of a national policy and plan for the health sector.

In September 1999, the Ministry of Health, assisted by WHO, produced a document presenting its short- and medium-term policy principles and objectives, entitled *Albanian health system reform: a position paper on policy and strategies for Albanian health system reform (22)*. The document formed a sound basis for further discussion on reform, but it was not a plan of action. A more comprehensive strategy was later formulated by Ministry of Health and WHO technical experts *(25)*, but the government has not yet approved it.

The establishment of the Department of Policy and Planning in 2000 was an important step in strengthening the planning capacities of the Ministry of Health. There were several arguments in favour of the new department.

- As part of the decentralization process that has begun in the country, the role of the Ministry of Health should shift in the direction of policy-making, planning, regulation and coordination.
- By developing a national policy and a comprehensive strategic plan for the health sector, the Ministry of Health will be better able to justify increased spending on health care to both the government and the donor community. The resulting policy and plan will also enable the Ministry of Health to invest budget and donor funds more effectively.
- A department devoted to health policy and planning could help establish a participatory consultation process, as well as promote greater transparency in setting priorities and allocating resources among different health subsectors and geographical areas.
- There is little continuity within the Ministry of Health, and its institutional memory has disappeared with changes in personnel. Each new government replaces its senior and even middle-level managers, and much documentation disappears with the replaced staff. The Ministry of Health has not been able to set up a system for preserving its "technical memory".
- The planning capacities of the Ministry of Health are weak, since day-to-day administration must take priority.

It is hoped that the new planning department can help in these areas. Yet a new structure does not necessarily mean new functions. Planning is a complex and chiefly political process, and it will take time for the new department to take over and perform successfully in the difficult environment and bureaucratic culture of the Ministry of Health.

Furthermore, the government and donors continue to invest in the health care sector without an adequate rationalization plan for its delivery system. The World Bank has proposed assisting the government to create a comprehensive regional master plan for the health care delivery system in Tirana, a plan that would cover all the health services under the TRHA as well as their relations to the hospital system. The current Ministry of Health leadership has shown enthusiastic support for this type of planning exercise, which will require facility mapping, facility medical and engineering surveys, consensus on service standards, needs analyses (staffing, facilities and equipment) and estimates of the investments and recurrent costs needed to implement the plan.

Regulation

The need for health care regulation in Albania has been growing, due to the decentralization of public health care administration and the recent increase in

private services. At present, regulation takes place through the bureaucratic system and is not separate from management. Few independent regulatory bodies have been established. The absence of a clear regulatory framework contributes to a number of problems.

- There is a lack of sufficient information on private providers and their services. The Ministry of Health's ability to collect and process information is limited. It does not register private providers every year, nor does it have a decent database on them.
- The Ministry of Health has difficulty elaborating standards and enforcing them. Enforcement imposes high administrative costs, and the government has limited resources. Recently, the Ministry of Health has made some effort to regulate private providers, requiring them to be licensed or close down. A pharmaceutical inspectorate has also been created to enforce observance of standards among drug dispensers, most of whom operate in the private sector.
- Decentralization has not been accompanied by a clear definition of responsibilities. Various government entities often lack the political will to discharge their duties, and sometimes do not even understand the rules and regulations. Such factors can create and maintain a high level of tension among different stakeholders in the health care system. Thus, there is tension between the Ministry of Health and the HII, between Ministry of Health district offices and local governments, between the HII and the TRHA, etc. Furthermore, central legislative bodies sometimes pass contradictory regulatory acts due to divergent interests, thus creating more confusion.

A considerable amount of work needs to be done on standards of care, quality assurance and consumer protection. Efforts to develop standards for hospital accreditation, which could be used to rationalize the distribution of hospitals, have progressed little. Some district hospitals have not been upgraded to regional hospitals because of a conflict of interest between districts. The hospital map of the country has yet to be drawn, and the accreditation process has stalled.

The Albanian Order of Physicians, established in 1993, has assumed responsibility for professional standards and for the registration of doctors. There are few performance incentives in the health care system, however, and professional self-regulation is weak. The General Medical Council of the United Kingdom (GMC) is offering the order assistance.

Professional self-regulation for nurses is even less developed, and the Nurses Association was established only recently.

Management

Management functions require urgent attention, and Albania does not have any professional management consultants. Managerial performance is judged more by political commitment than by effectiveness. Most funding is determined centrally by comprehensive budgets that are allocated at the start of each financial year. District administrators and health care managers have little flexibility and limited technical capacity to manage effectively. There is also an urgent need to establish management information systems, which would provide useful and accurate programme and budgeting information.

Other stakeholder groups, such as professional associations, unions and consumer groups, play little role in planning or regulation. Health service providers are still not accountable to their patients, despite the policy objective of the Ministry of Health to "put the patient at the centre of the system".

Decentralization of the health care system

The health care system in Albania remains highly centralized and hierarchical, despite some decentralization. Some administrative responsibility (but no political or policy responsibility) has devolved to the 36 districts, though they remain accountable to the Ministry of Health.

Responsibility for running and maintaining rural PHC facilities has largely devolved to the local governments. Rural PHC doctors primarily use these facilities but receive their salaries, based on capitation fees, from the Health Insurance Fund.

So far, most of the privatization has been carried out with dental practices and pharmacies. Hospitals, polyclinics, health centres and health posts remain publicly owned. Private medical practice and private insurance were legalized in 1992, and the private health sector is continually expanding, particularly through the increasing number of specialized outpatient clinics.

The recently formed HII is a new health sector entity. Eventually, the institute is intended to assume a larger health-funding role.

Though the decentralization initiatives noted here are now being implemented, no decision has been made about the extent or form of future decentralization. The Ministry of Health apparently intends to test different models before proceeding with a larger decentralization programme at the national level. In addition, other central bodies (such as the Ministry of Finance, Ministry of Local Governments, Ministry of Justice, etc.) are also involved in

the decentralization process, and their opinions on health sector decentralization will not necessarily agree with those of the Ministry of Health.

The pilot initiative in Tirana (for more details see the section *District directorates and the Tirana Regional Health Authority* under *Organizational structure of the health care system*) has demonstrated the challenges and difficulties of the decentralization process. On the one hand, the Tirana Regional Health Authority prefers to keep all health resources of the Tirana region under its direct management and control. The preferred model here is that of delegation of authority and responsibilities from a central body to a regional one. The alternative model is that offered by the Health Insurance Institute, as a direct purchaser of primary and secondary outpatient services from the public and private providers, in the region of Tirana. Many stakeholders are involved in this process, including the Ministry of Health, the MoF, the TRHA, the World Bank and DFID (through their consultant HLSP). It is not clear which model will prevail.

A second pilot initiative is that of the Durres regional hospital, which recently became a semi-autonomous entity funded directly by the HII. The results of these pilots will likely guide the next steps of the health system decentralization process.

Health care financing and expenditure

Main system of financing and coverage

Financing levels for Albanian health care remain very low and, for the last decade, the sector emphasis has been on how to do more with less. A key problem facing the government after the transition to multiparty democracy in 1992 was finding the financial resources to maintain essential health services, given the very small government budget.

There is little information on the scale of funding before 1990. In Communist ideology, health care was considered a nonproductive sector and thus a low priority. In 1987, health expenditure in Albania was estimated to be 3.0% of GDP, compared to a CEE average of 2.8% and an EU average of 7.3% *(26)*.

Albanian health services are funded through a mix of taxation and statutory insurance. The bulk of funding still comes from the state budget, but the tax base is problematic due to low incomes, the large informal economy and problems with tax collection. In 1999, health care was financed as follows: about 59% from the state budget, 29% from household payments, 4% from employer health insurance contributions and 8% from foreign donors (see Table 6). The HII received more than 17% of all health funds, with 8.5% coming from the state budget, 4.3% from employers and 4.4% from individual contributions.

While the state remains the major source of health care financing, its contribution shrank from around 84% in 1990 to less than 60% in 1999 as other funding, especially out-of-pocket payments, increased.

The MoF allocates money to the Health Insurance Fund, mainly to cover unwaged groups, and to the Ministry of Health. The MoF also allocates earmarked funds to local governments, mainly for primary care, including

Table 6. Sources of financing and expenditure, 1999

	Revenues (millions of leks)	% of total
State budget to Ministry of Health	7 300	47.5
State payment to HII	1 299	8.5
State payment to local governments	405	2.7
State subtotal	9 004	58.7
Pharmacy drugs	2 000	13.0
Service provider fees (including under the table)	1 016	6.8
Household contributions to HII	656	4.4
Dentistry	600	4.0
User fees ("secondary revenues")	120	0.8
Household subtotal	4 392	29.0
External financing	1 240	8.0
Employer contributions to HII	655	4.3
Total	15 291	100.0

Sources: MoF; HII; KPMG Consulting, 2001.

recurrent funds for some staff salaries, and capital funds to upgrade and maintain health centres and health posts. This local support amounted to 4% of the state health budget in the year 2000 *(8),* a figure that shows how underfinanced the basic health services in rural communities are. Inefficient use of these meagre funds by local authorities exacerbates the poor quality of preventive and curative services in rural Albania. In principle, local government can also raise revenue for health care, but the amount thus raised remains very small.

The Health Insurance Institute (HII)

The HII, established in 1995, is a national statutory body. It was established to secure an additional source of health care financing, offer a broader range of health care services, control administrative costs and ensure equity. A single payer system, rather than a multiple payer one, was deemed better able to cover the country's small population, act as a strong regulator and keep administrative costs low. The HII was created as an autonomous body, and in 1996 it was made accountable only to the parliament.

The HII remains by design a limited scheme, introduced in stages. Premiums have been kept low, with different rates for different income groups, and purchase a restricted package of health services and pharmaceuticals.

HII enrolment varies among different population groups. Most of the unwaged, including children, women who work at home and the elderly, are automatically covered by the state budget. Of the active workforce (70% of the population), about 40% was covered in 1999. Although farmers represent almost one quarter of the country's population, they are the group with the lowest enrolment – about 4% in 1999 *(27)*. One reason is that farmers cannot afford

both health insurance and social insurance contributions. Another is that the rural population is often poorly informed about the benefits offered by enrolment in the health insurance scheme. In a survey about the scheme, 72% of the rural residents asked had very little or no information at all about its benefits *(28)*. Finally, contribution incentives are weak: the scheme covers very limited services, and enrolment does not appear to confer any advantage. For though benefits are legally limited to those who make insurance contributions or have them covered by the state, in practice the distinction is not upheld, and doctors treat all patients without discrimination.

Insurance contributions are collected by the district offices of the Social Insurance Institute (SII). Contribution rates are set according to income rather than health risks. At present they amount to 3.5% of wages, split equally between employers and employees. Employee contributions, which are 1.7% of their net salary, are collected by employers as payroll deductions. The self-employed contribute between 3% and 7% of their incomes, depending on whether they live in rural or urban areas. Lower rates have been set for private farmers. As mentioned above, the state pays the contributions for the dependent population, which now account for nearly half of HII revenues (Table 7).

Table 7. HII revenues and expenditures

	1996	1997	1998	1999	2000
Revenues					
Employee/employer contributions	30%	29.3%	26%	26.5%	26.2%
Self-employed/miscellaneous contributions	28%	25%	27.5%	23.6%	27%
Farmer contributions	8%	0.7%	0.5%	0.9%	0.8%
State contribution	34%	45%	46%	49%	46%
Total percentage	100%	100%	100%	100%	100%
Total (millions of leks)	1 475	1 755	2 321	2 654	2 826
Expenditures					
Drug reimbursements	68%	74%	75%	75%	70%
Payments to GPs	25.5%	21%	18%	18%	22%
Administrative expenses/investments	6.5%	5%	7%	6%	7%
Public information/publicity				1%	1%
Total percentage	100%	100%	100%	100%	100%
Total (millions of leks)	1 270	1 623	2378	2 592	2 436

Source: HII.

The HII has achieved a budget surplus nearly every year since its inception in 1995. The surplus goes into a reserve fund, which was able to cover the 1997 deficit caused by the civil emergency.

Coverage has been introduced in stages. In the first stage, which began in 1995, only PHC physicians' salaries and essential pharmaceuticals were

covered. By 1997, coverage included GP services, and subsidies for the 278 products on the essential drugs list. During the first half of 2001, the list of subsidized drugs was extended to 308 *(29)*. In the Tirana Prefecture at the beginning of 2001, the HII also extended its coverage to all outpatient care services, including specialized outpatient care, specialist doctor payments, nurse and midwife wages and operating costs. The main party entering into contract with the HII is the TRHA. The contract clearly specifies a separate budget for each polyclinic and health centre under the TRHA. If successful, the model will be replicated in the rest of the country.

The HII has also started to be involved in financing secondary hospital services. In 2001, the insurance fund began funding the Durres regional hospital. It is not clear what kind of payment mechanism will be chosen for this arrangement. In order to estimate the real costs at this early stage of the experiment, the HII is giving the hospital block grants, based on its historical budgets, and collecting information on hospital expenditure by category. It is hoped that the contractual arrangements between the HII as purchaser and the Durres hospital as provider of services will be defined soon. The HII greatly needs technical assistance in this area.

In 2000, the HII spent 70% of its budget on drugs, 22% on general practitioner salaries and 8% on administrative costs and public campaigns (Table 7).

The HII has encountered inevitable implementation problems. Prices, reimbursement rates and premiums all need to be adjusted. Service providers do not differentiate between insured and uninsured patients. Administrative and funding arrangements between HII and SII funds remain hazy. However, the HII has elaborated a strategy to address some of these problems and prepare itself for further organizational development. The strategy proposes to increase individual contributions, modify the contribution collection system and introduce more sophisticated mechanisms to improve drug reimbursement. It also proposes increasing the incomes of GPs working in the PHC sector in order to boost PHC development *(30)*.

Health care benefits and rationing

Under the Communist regime, all citizens were entitled to free health care, with small co-payments for drugs. Drugs were sold in public pharmacies at subsidized prices, and were free in public pharmacies for cancer and tuberculosis patients and children under the age of one. The health care system was unable to provide a comprehensive range of services to the entire population,

however, and did not provide services such as some expensive surgeries, or high-technology diagnostics and treatment.

Eligibility for health care is now based on both citizenship and payment of insurance contributions. Access to free primary care and pharmaceuticals is restricted, in theory, to patients (and their dependants) who have paid their insurance contributions. However, some population groups, such as farmers, cannot afford insurance. The latest report on poverty in Albania indicates that almost 15% of the population lives in conditions of extreme poverty *(9)*. The state is considered responsible for low-income groups, and in practice, therefore, people are not refused medical services. Inpatient services at public facilities are by law offered free of charge to the entire population, although the quality of care is often low. This free care includes long-term treatment for conditions such as tuberculosis and cancer. During their first year, children are automatically insured by the state and receive free essential drugs. There are also co-payments for abortions.

All dental care has been privatized, except for emergency dental care and patients under the age of 18.

Access to health care services remains restricted by the country's inability to afford a full range of services and to replace facilities and services damaged during civil unrest. There is another major barrier to access in the many rural areas where doctors and nurses have left medical facilities due to economic and social factors.

Complementary sources of financing

To make up the shortfall in the state health care budget, extrabudgetary sources of finance have been sought from both patients and outside sources. The two main additional sources are consumer payments and foreign aid.

Out-of-pocket payments

Official out-of-pocket payments account for an increasing proportion of health care revenue, but the full extent of such payments is unknown. It is likely, however, that they prevent low-income people from obtaining services and pharmaceuticals. According to some estimates, out-of-pocket sources, excluding health insurance contributions, constituted 24.6% of total health expenditures in 1999 (see Table 6).

Patient co-payments are set at a low level and are not intended to be a major source of revenue. They apply principally to outpatient services and

pharmaceuticals, though not to inpatient care. Albanians have always paid part of their drug costs in pharmacies. The shift to a free market economy and the privatization of pharmacies resulted in price rises, but the increases have been largely mitigated by the health insurance subsidies for essential drugs. Pharmaceuticals on the essential list are fully or partly reimbursed, while other drugs, most dental care and some other services are paid for out-of-pocket.

Table 8. Household expenditures for health care services, 1999

Category	% of total
User fees ("secondary revenues")	2.7
Pharmacy drugs	45.5
Dentistry	13.7
Service provider fees (including under the table)	23.2
HII contributions	14.9
Total	100.0

Source: KPMG Consulting, 2001.

A 2000 study estimated household expenditures for the previous year to be 4 400 million leks, or 29% of total health care financing (Tables 6 and Table 8). User fees are legal payments made to health facilities, half of the fees going to the facilities and the rest going to the state budget, where it is reallocated to other health services. Payments to providers go directly to providers' pockets, mainly illegally in the form of under-the-table payments. Such payments are illegal because publicly employed doctors are not allowed to provide private services, with the exception of professors in the Faculty of Medicine at the University of Tirana. The figure on under-the-table payments is most probably an underestimate, taking into account benchmark comparisons with other countries *(31).* Health insurance premiums are individual contributions to the health insurance system. The tables include also an estimate of user payments for drugs in pharmacies and dental services in the privatized dentistry system.

Under-the-table payments to doctors and other health professionals are said to be widespread in Albania, but the magnitude of these payments is unknown *(10).* Such payments are common in CEE, including neighbouring countries such as Bulgaria and Romania. According to a World Bank report, *Investing in health,* under-the-table payments were estimated to be 25% of the total health revenue in Romania and about 20% in Hungary during the early 1990s *(31).* A survey conducted in Albania in 2000 concluded that under-the-table payments are most common in state hospitals *(28).* Everyone there from the cleaner to the surgeon is regarded as being involved in the practice. Among respondents, 87% admitted to having tipped a public hospital doctor and 86% a nurse. The survey concludes that the prevailing belief among the general public is that

such payment is necessary in order to get proper treatment, and in some cases, to get any treatment at all. More than a quarter of the respondents stated that a doctor implied they would not be treated if they did not pay. The majority said that they paid without being asked *(28)*. The survey reveals something about the economic and moral crisis that Albanian society is going through and raises some important questions on equity of access to health services.

Voluntary health insurance

Private insurance and private medical practice have both been legal in Albania since 1992. Due to the country's current economic and political condition, however, private insurers have not sought to enter the health insurance market. The Insurance Institute (INSIG) is the only private firm writing health policies, which it offers for limited periods to Albanians travelling abroad.

External sources of funding

External aid accounts for a considerable proportion of Albanian health care funding. During 1992 and 1993, it amounted to over one third of the country's public health financing. The real value of foreign aid doubled in 1996, but since domestic spending on health also increased during this period, the foreign aid share of the total declined to about 26% *(19)*.

Donors mobilized sizeable funds for the health sector during the Kosovo crisis. However, by the end of August 1999, the overwhelming majority of the refugees had returned to Kosovo, which was now under the protection of NATO troops. Most of the funds available for health care in Albania had to be spent quickly. The World Bank Office in Tirana estimated in June 2000 that the total funds for health projects under way or in preparation was about US $160 million, a record for the last ten years of donor activity and a direct effect of the refugee crisis *(21)*. According to estimates, external assistance to the health sector in Albania amounted to 8% of the country's total health financing in 1999 (Table 6).

External aid to Albania comes from foreign governments and NGOs. The main contributors have been the World Bank, the European Community Humanitarian Office (ECHO), the governments of Germany, Italy, France, Switzerland and Japan, the United States Agency for International Development (USAID), the governments of the United Kingdom and Greece, the Roman Catholic Church, the Organization of Petroleum Exporting Countries Fund for International Development (the OPEC Fund), UNICEF, the United Nations Population Fund (UNFPA) and WHO.

Health care expenditure

There are few statistics on health care expenditure spending in Albania before 1992. Statistics since then also vary according to the source, or are simply unavailable, since the Ministry of Health has been unable to produce a systematic and reliable time series. Health expenditure figures from a given year are also often revised in subsequent years.

Table 9. Health care expenditures expressed as % of GDP

Public sector health expenditures (% of GDP)

1994	1995	1996	1997	1998	1999	2000
–	–	2.29%	2.06%	1.93%	1.96%	2.08%

Source: MoF, 2000.

Total health expenditures (% of GDP)

1994	1995	1996	1997	1998	1999	2000
2.8%	2.9%	3.0%	2.7%	2.6%	2.8%	3.0%

Source: Ministry of Health estimates based on MoF data.

Health care expenditure has to be considered within the context of the country's struggling economy, and its low and fluctuating GDP. Public spending on health care has been very low in recent years and has shown a decreasing tendency in spite of its increasing share of the public budget in recent years (see Table 10).[3] Fig. 3, based on information from WHO/EURO's health for all data, shows the health spending to have peaked at nearly 5% in 1991 only to fall dramatically in subsequent years. Fig. 4, showing the same indicator for all the countries of the WHO European Region, assigns Albania a share of 2.8%, though it should be noted that this figure is for the year 1994. According to data in the upper half of Table 9, public health care spending fell from 2.29% of GDP in 1996 to 1.93% of GDP in 1998 before increasing slightly to 2.08% of GDP in 2000 *(9).* The more recent figure of 2.08% puts Albanian spending on health care at only slightly more than one third of the CEE average and is one of the lowest proportions of GDP spent on health in the entire European Region.

Actually, the Albanian figures are underestimates, since the considerable amount of out-of-pocket payments are not included in the calculations. If they were, the share of health care spending rises to about 3% of GDP, as shown in the lower half of Table 9. Yet it remains a very low figure compared to most other countries in the region.

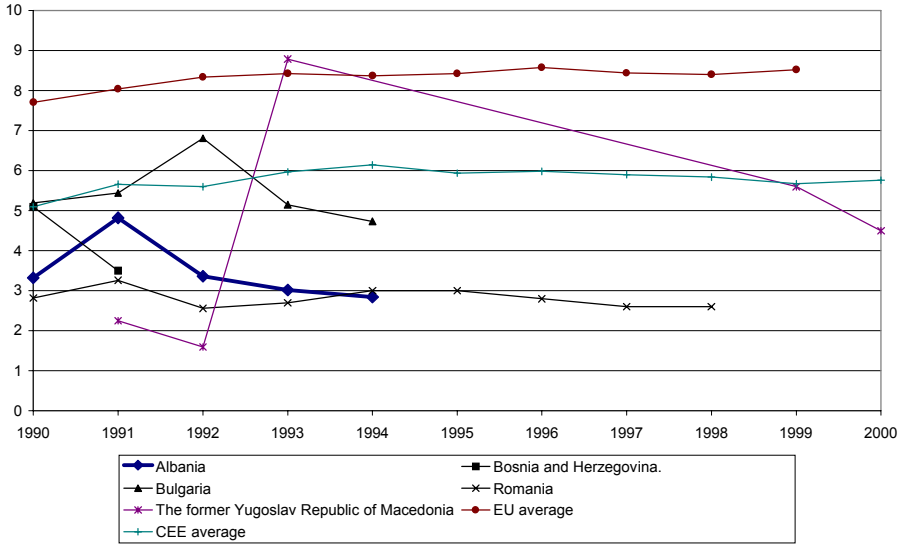
[3] The explanation for this paradox is that overall budgetary expenditures have fallen as a share of GDP, so despite increasing allocations for health care, its share of the GDP has been falling.

Table 10. Percentage of public budget allocations in health and education

	% of budget allocations by years				
	1996	1997	1998	1999	2000
Health	7.7	7.6	7.6	9.2	9.9
Education	13.0	13.7	12.9	12.9	12.3

Source: MoF, 2000.

Fig. 3. Trends in health care expenditure as a share of GDP (%) in Albania and selected countries

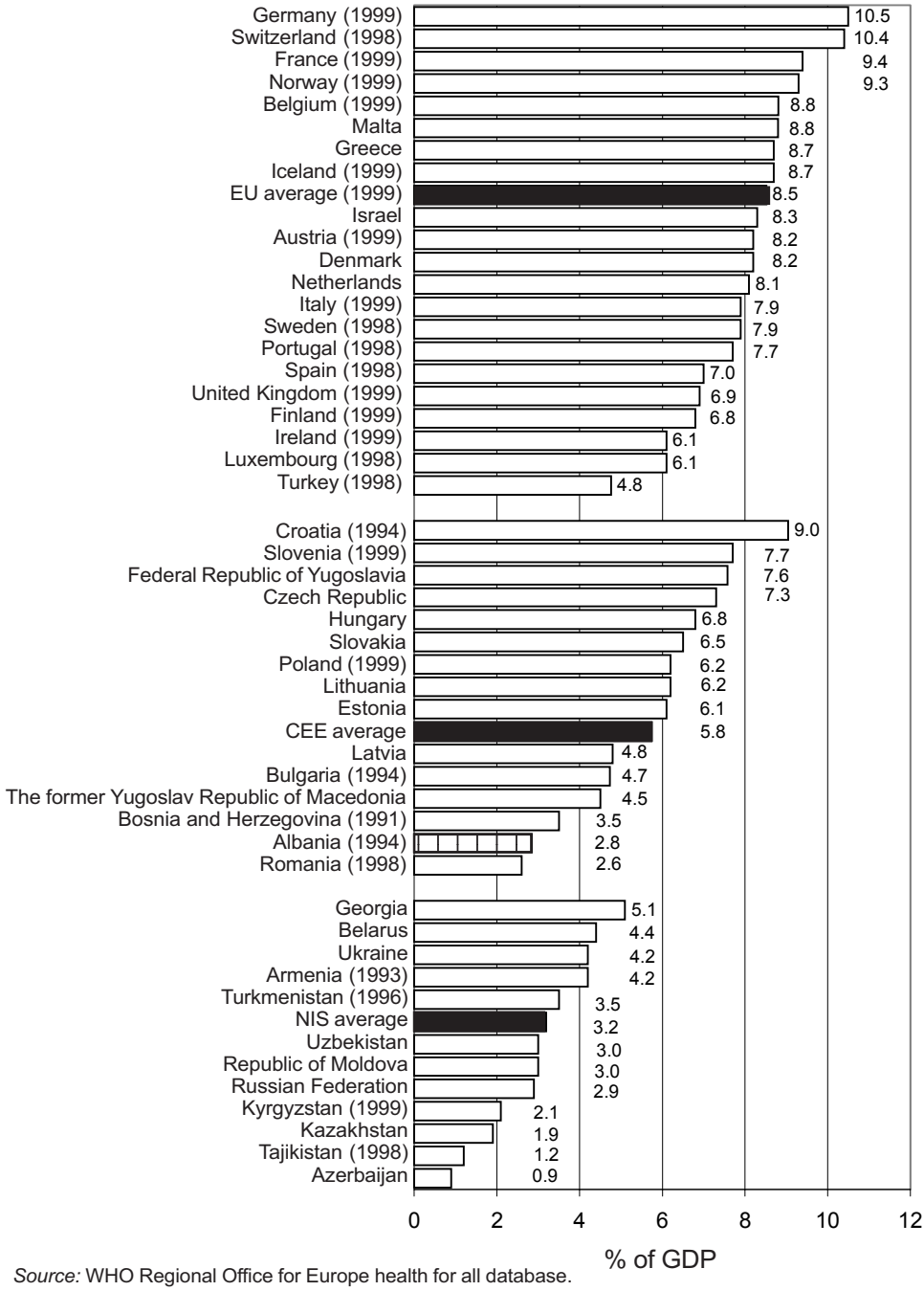


Source: WHO Regional Office for Europe health for all database.

Health care spending has gone through several phases in the 1990s. During the severe recession of 1990–1992, spending on health care nearly halved. From 1993 until 1996, it increased each year, and by 1996 was US $85.14 million *(10)*. It then dropped to US $70 million in 1997, and jumped to US $108 million in 1999, amounting to about US $33 per capita in 1999. This figure would be substantially higher if expressed in PPP terms.[4] But despite the upward trend in health care spending in recent years, it remains very low and is not at all sufficient to provide quality health care to all Albanians. Moreover, it should be noted that a substantial portion of the increased spending has been due to the increased proportion of out-of-pocket payments, a development that does not favour equity or access to health care.

[4] As Fig. 5 indicates, spending per capita was US $PPP 79 in 1994, and so would be higher today, given the increases in real spending on health care in the interim.

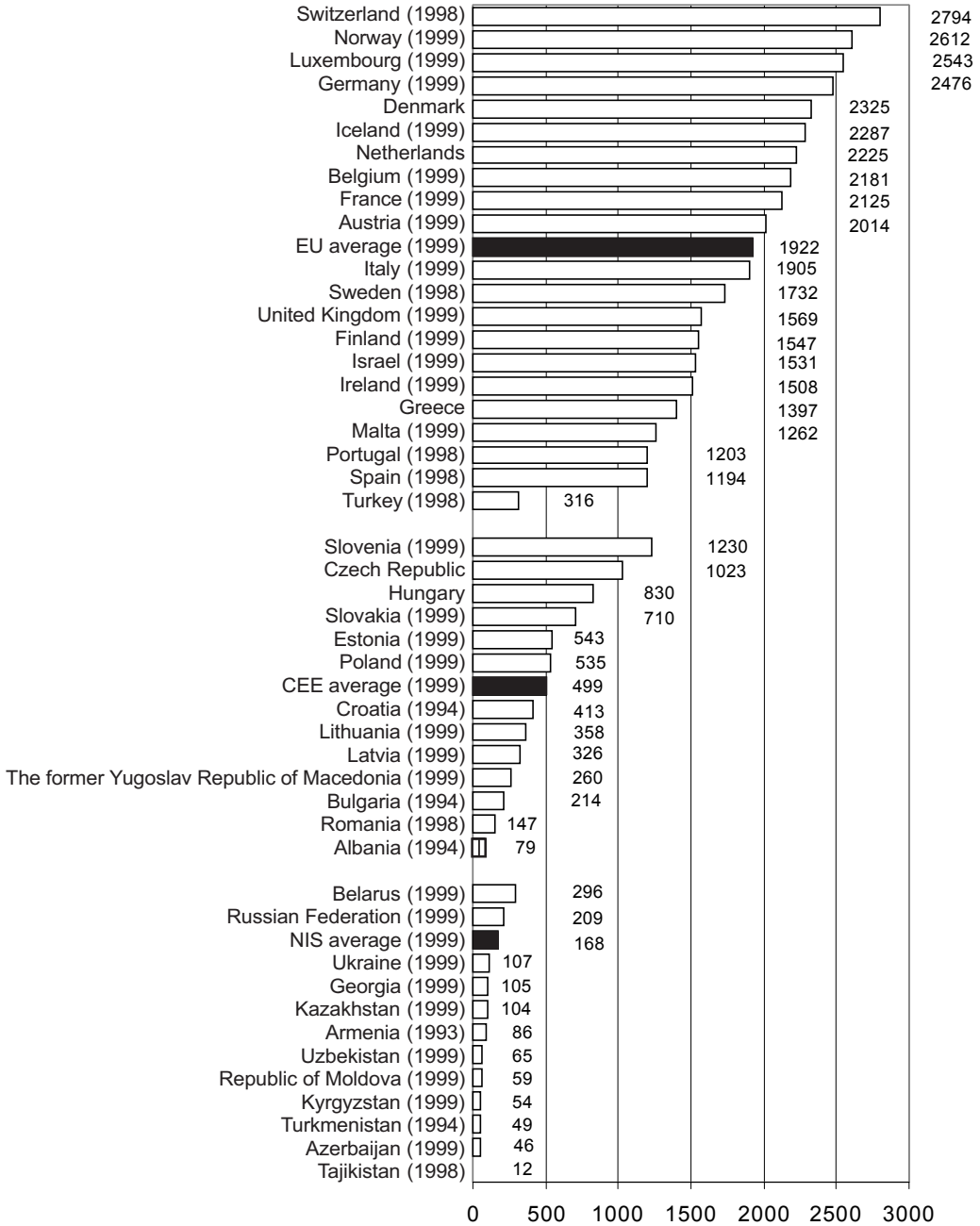
Fig. 4. Total expenditure on health as a % of GDP in the WHO European Region, 2000 or latest available year (in parentheses)



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

CEE: central and eastern Europe; EU: European Union; NIS: Newly independent states.

Fig. 5. Health care expenditure in US $PPP per capita in the WHO European Region, 2000 or latest available year (in parentheses)



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

CEE: central and eastern Europe; EU: European Union; NIS: Newly independent states.

In the revised *Medium-term expenditure framework: 2001–2003,* published in December 2000, the MoF identified four critical issues in health care financing:

1. insufficient financing for the health sector as expressed in GDP share;
2. inefficient utilization of resources;
3. falling funding levels for PHC, which, combined with organizational and management factors, has led to an overutilization of secondary care in hospitals and outpatient clinics; and
4. the allocation of resources on the basis of facilities rather than population distribution and needs, thus creating problems with equity of access.

To address these issues, the government has elaborated a medium-term strategy on public health care spending *(9)* with the following objectives:

- increase the level of resources going to the health care sector during the next three years, to ensure better funding of health services and reverse the decline in health spending as share of GDP;
- increase funding for PHC services substantially, to improve access for the whole population and reduce unnecessary demand for secondary hospital services;
- restructure the hospital sector, adjusting each facility's services to the needs of its catchment area;
- make tertiary care more cost-effective; and
- extend the coverage of the health insurance scheme.

Structure of health care expenditure

Table 11 presents health care expenditure in Albania during the last five years. The table does not include out-of-pocket payments, for which there are no reliable figures.

According to these statistics, in 2000 nearly 57% of public health sector spending went to secondary inpatient and outpatient care, compared to 51% in 1996. The Tirana University Hospital absorbed 8.6% of total spending compared to 10.3% in 1996. Spending on PHC services and public health programmes fell from about 33% in 1996 to about 23% of health expenditure in 2000.

The state's capital investment in the health system varies considerably from year to year. In 1996, it accounted for 12% of the government health care budget, with 46% of the funds allocated to new construction, 32% to rehabilitation of existing infrastructure and the remainder to equipment purchase *(10)*. In 2000, investments had increased to 32% of the total (Table 12).

Table 11. Public expenditure on health (including health insurance) by sub-sectors

Subsector	1996		1997		1998		1999		2000	
	Leks	%	Leks	%	Leks	%	Leks	%	Leks	%
Planning and management	108	1.5	128	1.6	250	2.5	310	2.7	396	3.0
Public health and PHC services	2 404	33.5	2 464	31.1	2 878	29.3	2 852	24.8	3 063	23.2
Hospital services	2 920	40.7	3 161	40.1	3 692	37.5	5 174	45.0	6 362	48.0
Tirana University Hospital Centre	745	10.3	789	10.1	959	9.7	1 017	8.8	1 130	8.6
Health Research Institutes	128	1.8	138	1.7	274	2.8	207	1.8	544	4.1
Basic drug subsidies	867	12.2	1 202	15.4	1 783	18.2	1 941	16.9	1 705	13.1
Total	7 172	100.0	7 882	100.0	9 836	100.0	11 501	100.0	13 200	100.0

Source: MoF, 2000; HII.

Table 12. State budget allocations on healthby categories (millions of leks)

Budget lines	1996	1997	1998	1999	2000
Personnel and insurance	3 437	3 628	4 083	4 341	4 763
Maintenance and operations	1 804	1 984	2 474	2 517	2 623
Recurrent expenditures subtotal	5 241	5 612	6 557	6 858	7 386
Domestic capital investment	635	571	802	847	1 130
Foreign capital investment	57	89	458	1 240	2 300
Capital investment subtotal	692	660	1 260	2 087	3 430
Total budgetary expenditure	5 933	6 272	7 817	9 005	10 816
State contribution to Health Insurance Fund	506	790	1 070	1 300	1 300
Grand total	6 439	7 062	8 887	10 245	12 116

Source: MoF, 2000.

According to the information published by the MoF, in the period 1996–1999, investment expenditure represented an average of 18% of the total expenditure for health care, with 44% of these expenditures originating from foreign sources *(9)*. This very high proportion of investment can be explained in part by the large foreign contribution, much of which did not correspond to real investments but included such diverse activities as technical assistance and capacity building. In addition, the investment category also includes some planned projects that were not carried out.

The problem with capital investments in the Albanian health sector is that they are made without any clear medium- or long-term plan, and with no regard for ongoing costs like consumables and maintenance. In addition, renovated or new health facilities operate in a difficult environment with severe infrastructure

deficiencies, such as intermittent electricity, contaminated water systems and transport problems due to bad roads. The result is a system where renovated and new structures often cannot offer high-quality care to patients because of insufficient operating funds, poor management and damaged infrastructure.

Health care delivery system

Albanian health care services are delivered in poor facilities with inadequate equipment. The buildings were constructed mainly between 1960 and the early 1980s. Capital investment then lagged, so that by the 1990s health facilities were generally old and deteriorating with obsolete equipment *(18)*. The government managed to increase investment during the 1990s, as mentioned above, but health care facilities also sustained considerable damage during the decade's civil disturbances.

Primary health care and public health services

A basic primary health care system orientated towards MCH was established prior to 1990. However, in 1991 and 1992, and again in 1997, many PHC facilities were damaged. According to the Ministry of Health Statistics Unit, the number of health centres fell from 702 in 1994 to 564 in 2000, while the number of health posts decreased from 1973 to 1582 during the same period.

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 general practice. A typical health post is staffed by a nurse or midwife and provides maternity care, child health services and immunizations. Rural health services have ceased to function in some areas, however, due to equipment shortages and staff resignations.

In urban areas, large polyclinics provide specialist outpatient care, but now they are also used by people as their first point of contact with medical care. Previously, patients had to use GPs to obtain a referral to specialists, even though GPs were not highly respected as health professionals. This referral system is no longer functioning. The Ministry of Health has introduced fees

for those who bypass their GPs but, so far, this disincentive has had little effect. The problem is compounded because specialists want to attract patients directly, since under-the-table payments form an important source of their income. The habit of bypassing PHC services has been hard to change, and patients continue to use specialists for first contact care.

The nonfunctioning referral system and the lack of confidence in GPs help account for the extremely low number of outpatient contacts per person per year, 1.6 in 1999. As Fig. 6 indicates, only one country in the European Region, Georgia, has a lower outpatient contact rate.

Local governments now own PHC facilities in rural areas. In urban areas, health facilities are still owned by the Ministry of Health. This division in the country's decentralization of health services has led to underfunded rural health services and better-funded urban health services.

Table 13. PHC facilities, 1994–2000

	1994	1995	1996	1997	1998	1999	2000
Health centres	702	622	637	637	637	567	564
Health posts	1 973	1 832	1 747	–	–	1 584	1 582

Source: Ministry of Health Statistics Unit.

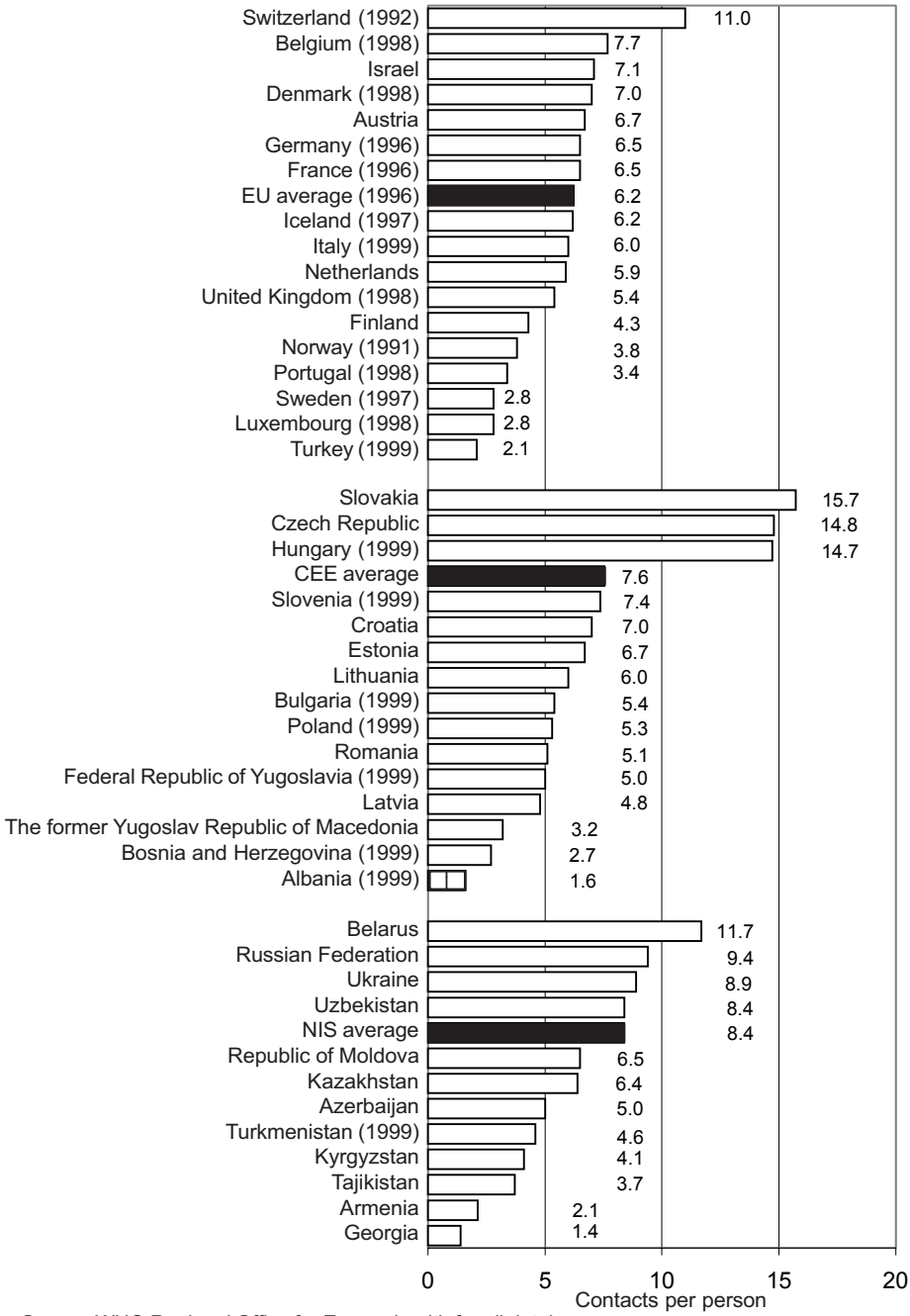
Reform of the PHC system began in 1992, guided by Phare, the World Bank and WHO. PHC facilities remain publicly owned, with the exception of licensed private pharmacies and dental clinics.

The PHC policy that was developed in 1997 with EU support states that there should be at least one health centre in each commune and one health post in each village *(32).* Health centres are supposed to be on separate sites than polyclinics, medical centres and hospitals. Many health centres were renovated and re-equipped in the period 1999–2000, and the Ministry of Health is rebuilding others with financial assistance from ECHO, the World Bank and the Government of Germany.

The policy proposes that primary care teams be led by GPs. The planning guideline is for one GP per 2000 inhabitants in urban areas, and one per 1700 in rural areas. The PHC team is supposed to act as a gatekeeper for secondary care, although there is no mechanism to ensure that it will. Patients are free to register with the doctor of their choice, whom the HII pays a capitation fee that is weighted for geographic area and other criteria.

The PHC network is mainly orientated towards providing services for vulnerable groups such as children, women and the elderly. Renovating and building health centres is considered a way to improve health care access, especially for rural communities. However, some reports indicate that PHC

Fig. 6. Outpatient contacts per person in the WHO European Region, 2000 or latest available year (in parentheses)



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

CEE: central and eastern Europe; EU: European Union; NIS: Newly independent states.

centres are not fully utilized, especially by people living close to urban areas. In addition, the lack of sufficient funds and supervision prevents the centres from being in good operating condition and providing quality services.

Health centres in rural areas have a limited number of beds, most of them for maternity care. In 1999 there were 166 health centres, with a total of 679 beds. Even so, bed utilization in these facilities is extremely low, and the bed occupancy rate does not exceed 10% *(12)*.

The Ministry of Health, with assistance from donors, has started a process of integrating separate health services into PHC teams. As part of this process, tuberculosis prevention services, part of a national programme administered through the districts, will become part of primary care. Public health and preventive services such as school health and health education will also be included, along with MCH services and family planning. Recently, mental health services are also being tried at the PHC level of primary care, with support from the Government of Sweden and WHO. A pilot integration project is being set up in the Tirana Prefecture in connection with the development of its regional health authority. The World Bank is supporting this effort.

MCH is a high priority for any country with a youthful population. A high proportion of women was said to receive prenatal care under the Communist system, partly because maternity leave benefits were tied to health centre visits. Prenatal care services are now faltering in many areas. For example, in 1999, 19% of the pregnant women did not attend a prenatal check-up until after 28 weeks of pregnancy and, of this group, 65% were living in rural areas *(12)*.

In October 1999, the Ministry of Health, assisted by WHO and UNFPA, conducted safe motherhood needs assessments in five districts and six maternity hospitals. These assessments were intended to be the first step towards the formulation of a safe motherhood national plan. The main findings of the survey depict a daunting situation *(33)*.

- Health centre midwives do not have the required skills to perform their tasks, and they work under difficult conditions, with low salaries and infrequent supervision.
- Essential drugs for obstetric care are missing at all levels of care, and those drugs that are available are sometimes used inappropriately.
- Equipment for maternal and neonatal care is missing and maintenance capabilities are minimal.
- Many delivery practices are substandard, and there are differences in the quality of care among different facilities.
- The lack of essential equipment and skills leads to inadequate newborn care and resuscitation practices.

These findings may help explain why 45.6% of Albania's infant deaths occur during delivery and in the early neonatal period.

The government has also adopted a family planning policy linked to better RH services. Family planning was practically nonexistent before 1991. In the absence of other alternatives, women have often resorted to abortion, which was legalized in 1992. The legalization resulted in a tremendous increase in the abortion rate, which reached 47.6 abortions per 100 deliveries in 1996. In 1999, the rate had decreased to 34.4 (Table 3).

As noted above, dental care has been almost entirely privatized, although free dental care is still available in emergencies and for children up to the age of 18 in school-based clinics. These clinics suffer from a shortage of good equipment however, and their staff lack adequate training.

Public health services

The IPH, reorganized in 1995 from the previous research institute in hygiene and epidemiology, is directly accountable to the Minister of Health. It has a staff of about 150 and is larger than the Ministry of Health head office. The institute collects public health statistics, organizes and participates in health surveys, runs immunization programmes, monitors the environment and collects data on health status. It also offers advice on public health policy, provides technical support and acts as a national research and training centre. In early 2001, the National Directorate of Health Education and Promotion was integrated into the IPH, which assumed its responsibilities. The IPH is developing a national education and promotion strategy, with assistance from the United Kingdom Health Development Authority and funding from the World Bank *(34)*.

Much of the responsibility for public health lies with the district public health directorates and PHC directorates, which have two distinctive structures and sets of responsibilities. The directorates are accountable to both the IPH and the Ministry of Health. Local authorities are directly responsible for waste disposal, drinking-water supplies and some forms of environmental protection. Government sanitary inspectors are the responsibility of the Ministry of Health.

The National Blood Transfusion Centre is based in Tirana, and there is a blood collection centre near most district hospitals. Albania is currently experiencing a blood donor crisis, and is struggling to move away from paying donors toward voluntary, free blood donations.

Albania is an "epidemic-prone" country, and the IPH, WHO and UNICEF have drawn up contingency plans for epidemics. One reason for its vulnerability is a widespread lack of basic amenities. According to World Bank estimates,

fewer than 90% of the families in urban areas have access to piped potable water, while in rural areas fewer than 50% do. Fewer than 5% of the rural families have sewerage access. Urban families have running water for only a few hours a day, and even then it is often contaminated by sewerage system leaks *(13).*

During the April 1997 civil riots, the system for reporting disease broke down in half the districts, as did waste management in all districts except Tirana *(7).* With foreign assistance, the IPH and many districts throughout Albania have been improving systems for monitoring infectious diseases. A relatively effective system called the Albanian Epidemiological Reporting Tool (ALERT) has been put in place, and it allows a rapid monitoring and reporting of the infectious diseases that have the greatest potential for causing epidemic outbreaks.

According to the IPH, the significant infectious diseases in Albania are viral hepatitis, with an incidence of 133 cases per 100 000 people; tuberculosis, with 21 new cases per 100 000; measles, with 23 cases per 100 000; and mumps, with 30 cases per 100 000. In addition, the incidence of epizootic diseases is increasing in the country, mainly due to deficient veterinary control of domestic animals. Thus, in the period 1995–1999 the incidence of brucellosis increased threefold, reaching a level of 13.4 per 100 000 *(35).* The same pattern is observed in the incidence of anthrax, which increased from 1.9 to 2.8 per 100 000 in the same period. On the other hand, in 1999 there were no registered cases of poliomyelitis, diphtheria, tetanus or malaria.

The Ministry of Health has put considerable effort into achieving good immunization coverage of children and in maintaining cold chain conditions for vaccines. After a drop in immunization rates in the early 1990s, due to the budget crisis and civil unrest, the rates have improved, mainly through direct assistance from UNICEF, WHO and the Global Alliance for Vaccines and Immunization (GAVI). In 1994, Albania included the hepatitis B vaccine in its compulsory immunization schedule for newborn babies, children and adolescents up to the age of 18. In 2001, the rubella vaccine, which will be administered as a combined rubella–measles injection, was added to the schedule, bringing to eight the number of vaccine-controlled diseases included in the compulsory immunization programme. In addition, the Ministry of Health runs an antitetanus programme for all pregnant women, and it conducted a rubella immunization campaign in 2001 for all women of reproductive age (15–45 years old).

In 1999, over 90% of the country's children were immunized against a range of infectious diseases *(36),* including immunization of all the newborn

against hepatitis B. In 2000, 98% of the children were reported immunized against measles (Fig. 7). However, there are still occasional measles outbreaks in the country; 1901 cases were reported in 1998, and 797 cases in 1999 *(14).* It should be noted that serious questions remain concerning vaccine quality, which might account for such outbreaks in the face of high coverage. There was a poliomyelitis outbreak in 1996, with a total of 138 cases and 16 deaths. The last case of poliomyelitis caused by a wild virus was registered the same year in November *(14).* The poliomyelitis vaccination campaigns and routine immunizations achieved a 97% coverage of Albanian children in 1999, and no poliomyelitis cases have been registered since December 1996. In 1999, the lowest immunization rate among children was 83% for tuberculosis, and the highest was 97% for poliomyelitis, diphtheria, tetanus and whooping cough *(36).* While all vaccines since 1992 have been supplied by UNICEF or imported, there remain problems with vaccine quality control.

Secondary care

Hospitals remain publicly owned, most of them by the Ministry of Health. It plans to reorganize hospitals at three levels: national, regional (prefecture) and district.

Albania's ratio of hospital beds to population is among the lowest in Europe. In 1992, there were 160 hospitals in Albania, with a total of 14 000 beds, or 4.0 beds per 1000 population (see Table 14). This figure included many small rural hospitals that could not be regarded as secondary care providers.

The main change since 1992 has been the closure of many poorly equipped small hospitals, mostly rural. Some of them have been converted into health centres. There are now 51 hospitals in the country, including specialist hospitals and a military hospital. The number of acute care hospital beds fell drastically, from 14 000 in 1992 to 9600 in 1996, before increasing again to 10 197 in 2000 *(12).* Long-term care beds have always been in short supply in Albania. Exceptions included the psychiatric hospitals, as well as the now-closed "dystrophic hospitals", where severely malnourished children were treated, although the government did not acknowledge the existence of malnutrition in the country.

In 2000, there were 3.2 hospital beds per 1000 population. Table 14 shows the gradual reduction in bed numbers since 1992. Fig. 8 and Fig. 9 depict the change in bed numbers that occurred in Albania in the period 1990–1998 in

Fig. 7. Levels of immunization for measles in the WHO European Region, 2000 or latest available year (in parentheses)

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

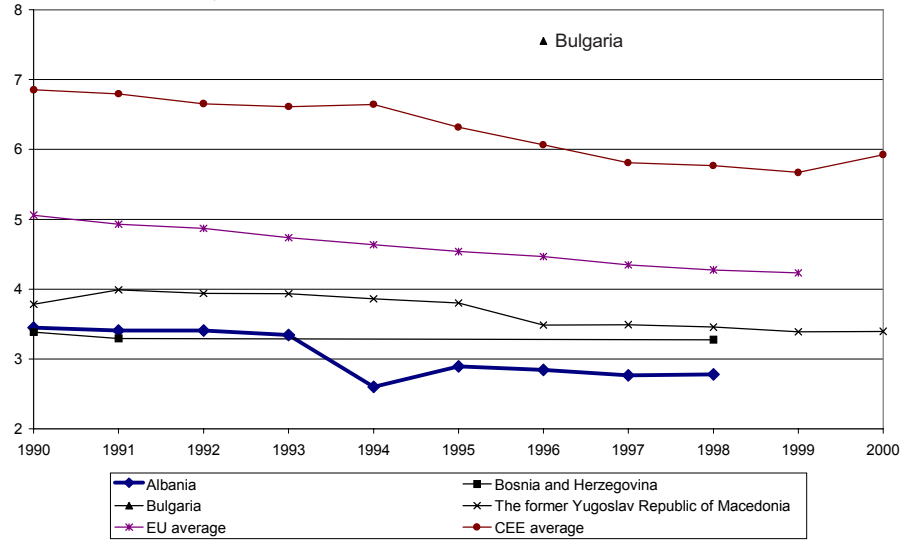
Table 14. Inpatient utilization and performance, 1992–2000

	1992	1993	1994	1995	1996	1997	1998	1999	2000
Hospital beds per 1000 population[a]	4.0	3.8	3.0	3.2	3.1	3.0	3.0	3.0	3.2
Admissions per 100 population[b]	–	8.96	8.67	8.96	8.8	7.7[c]	8.27	8.0	–
Average length of stay in days[a]	12.7	9.0	9.0	8.2	8.1	7.9	7.6	7.1	–

Sources: [a] Ministry of Health Statistics Unit; [b] INSTAT, 2000.
Note: [c] This number must be regarded with caution, since in 1997 Albania experienced terrible civil turmoil, and many people were injured by firearms. It is probably not a reliable figure.

comparison with selected countries in the European Region.[5] It is obvious that very few hospital beds are available in Albania in comparison to other CEE countries. Table 15 indicates that Albanian bed numbers are the lowest of all CEE and all the newly independent states of the former Soviet Union (NIS) shown. On the other hand, it should be noted that a different picture emerges when Albania is compared with western European countries, where several have even lower bed numbers – Finland, Israel, Sweden, Turkey and United Kingdom – while others have bed numbers that are nearly as low.

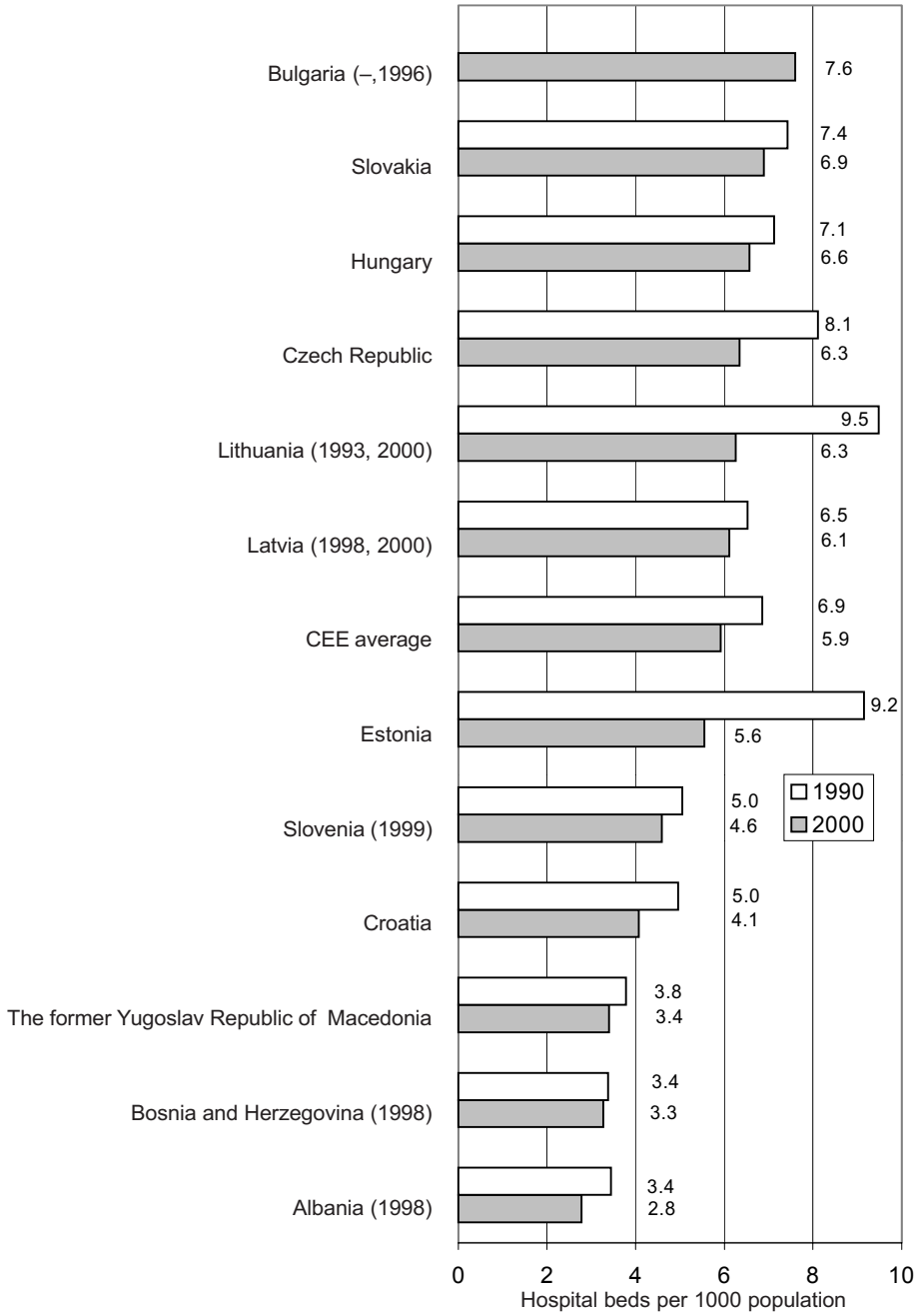
Fig. 8. Hospital beds in acute hospitals per 1000 population in Albania and selected countries , 1990–2000



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

[5] The data from the health for all database (Fig. 8 and Fig. 9) differ slightly from the Ministry of Health data in Table 14. The discrepancy may be due to conceptual differences in measuring bed numbers. Comparisons are further complicated by the fact that Fig. 8, Fig. 9 and Table 15 refer only to acute hospitals, while Table 14 refers to all hospitals.

Fig. 9. Hospital beds in acute hospitals per 1000 population in central and eastern Europe, 1990 and 2000 or latest available year (in parentheses)



Source: WHO Regional Office for Europe health for all database.
CEE: central and eastern Europe.

Albania

Table 15. Inpatient utilization and performance in acute hospitals in the WHO European Region, 2000 or latest available year

Country	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
Western Europe				
Austria	6.2	27.2	6.3	75.5
Belgium	5.5[b]	18.8[b]	8.7[b]	79.9[b]
Denmark	3.3[a]	19.1	5.5	79.9[a]
EU average	4.2[a]	19.0[b]	8.2[b]	77.0[b]
Finland	2.4	20.2	4.3	74.0[e]
France	4.1[a]	20.0[a]	5.5[a]	77.4[a]
Germany	6.4[a]	20.3[a]	10.7[b]	81.6[b]
Greece	3.9[a]	14.5[c]	–	–
Iceland	3.7[d]	18.1[e]	6.8[e]	–
Ireland	3.0[a]	14.1[a]	6.5[a]	83.0[a]
Israel	2.3	17.5	4.3	94.0
Italy	4.5[b]	17.1[b]	7.1[b]	74.1[b]
Luxembourg	5.5[b]	18.4[f]	7.7[b]	74.3[f]
Malta	3.7	11.2	4.6	75.5
Netherlands	3.3	9.1	7.7	58.4
Norway	3.1	15.5	6.0	85.2
Portugal	3.1[b]	11.9[b]	7.3[b]	75.5[b]
Spain	3.0[d]	11.2[d]	8.0[d]	77.3[d]
Sweden	2.5	15.6[b]	5.5[a]	77.5[d]
Switzerland	4.0[b]	16.4[b]	10.0[b]	84.0[b]
Turkey	2.2	7.6	5.4	58.7
United Kingdom	2.4[b]	21.4[d]	5.0[d]	80.8[b]
CEE				
Albania	2.8[b]	–	–	–
Bosnia and Herzegovina	3.3[b]	7.2[b]	9.8[b]	62.6[a]
Bulgaria	–	14.8[d]	10.7[d]	64.1[d]
CEE average	5.9	19.1	8.3	72.8
Croatia	4.1	13.9	9.2	86.3
Czech Republic	6.3	18.7	8.8	70.7
Estonia	5.6	18.7	7.3	66.1
Hungary	6.6	22.4	6.7	72.5
Latvia	6.1	20.0	–	–
Lithuania	6.3	20.9	8.3	76.0
Slovakia	6.9	18.9	9.4	71.0
Slovenia	4.6[a]	16.1	7.6[a]	73.2[a]
The former Yugoslav Republic of Macedonia	3.4	8.9	8.4	60.1
NIS				
Armenia	4.9	4.9	10.3	28.2
Azerbaijan	7.3	4.7	15.4	28.5
Belarus	–	–	–	88.7[f]
Georgia	4.3	4.5	7.8	83.0
Kazakhstan	5.5	14.1	11.5	97.0
Kyrgyzstan	6.1	15.5	12.3	90.2
NIS average	6.4	15.3	12.9	84.6
Republic of Moldova	6.3	13.1	11.9	66.6
Russian Federation	9.2	21.1	13.5	85.8
Tajikistan	5.9	9.0	13.2	59.8
Turkmenistan	6.0[c]	12.4[c]	11.1[c]	72.1[c]
Ukraine	7.2	18.4	12.7	88.1

Source: WHO Regional Office for Europe health for all database.
Note: [a] 1999, [b] 1998, [c] 1997, [d] 1996, [e] 1995, [f] 1994, [g] 1993, [h] 1992, [i] 1991, [j] 1990.

In spite of the relatively low numbers of hospital beds, Albania also has a low hospital admission rate. It was 8.0 per 100 inhabitants in 1999 (see Table 14), which is much lower than most other countries of the European Region (see Table 15).[6] According to surveys, poor people in Albania sometimes prefer not to be hospitalized because they cannot afford the under-the-table payments demanded by doctors and other personnel *(28).* In addition, the poor quality of services, lack of drugs and unhygienic conditions discourage hospitalization even when it is necessary.

On the other hand, an unpublished World Bank report *(37)* indicates that the number of inpatients per hospital bed in Albania was 26 in 1998. This figure was much higher than that reported for most other CEE countries, which ranged from 17 (Bulgaria) to 30 (Hungary). Considering Albania's very low number of outpatient visits per capita (1.6 in 1999, as shown in Fig. 6), its high number of inpatients per bed is probably best explained by the absence of a functioning gatekeeper system, as well as lack of confidence in the PHC system and its doctors. This means that Albanians bypass primary level doctors (when available) and go directly to the hospital, even for diagnosis and treatment of conditions that GPs would normally take care of *(37).* However, this hypothesis needs further elaboration and studies to be confirmed.

The average length of stay in 1992 was 12.7 days, but it fell to 7.1 days in 1999 (Table 14). As Table 15 suggests, this figure is low for the region but by no means the lowest, especially compared to western European countries, quite a few of which have even shorter lengths of stay. One explanation for the relatively short length of stay in hospital is the lack of equipment and drugs and the poor quality of services. Hospital bed occupancy was reported to be 54% in 1990 and 48.7% in 1999 *(12),* which is certainly quite low compared to western European countries (see Table 15).

Inpatient secondary care is provided mainly by district hospitals. The district hospital map in Albania is quite complicated at present and strongly reflects historical patterns: there are 20 hospitals of 100 to 400 beds, and 22 smaller hospitals. District hospitals provide a minimum of four basic services: internal medicine, paediatrics, general surgery and obstetrics/gynaecology. They admit patients through their casualty wards, as well as through PHC referrals. A few have been upgraded to the level of regional hospitals to provide advanced secondary care.

In 1992, the Ministry of Health decided to upgrade between 6 and 12 district hospitals to regional hospitals that would each feature about 500 beds and provide a wider range of medical and surgical specialties. work has finally begun on three of these hospitals, two subsidized by the World Bank and a

[6] Again, the figures in Table 14 and Table 15 are not directly comparable; see the previous note.

third one by the OPEC Fund. It has been politically difficult to determine which hospitals would be upgraded to 10 or 12 specialties, and which ones would remain district hospitals or even be downgraded to just the four basic services.

The national hospitals remain highly specialized. Patients needing tertiary treatment go to the 1500-bed University Hospital or to other specialist hospitals in Tirana. There are also hospitals for psychiatric care, tuberculosis treatment and rehabilitation.

There is only one nongovernmental hospital, which is in the process of being built. The Catholic Church is investing in a 200-bed private hospital in Tirana, but the project is taking much longer to complete than expected. It is not yet clear how this hospital will be funded, nor how much the public sector will contribute to its operation.

All polyclinics, except for those in Tirana, are the responsibility of district hospitals. The polyclinics, therefore, are headed by a district hospital director and use hospital staff. The Ministry of Health intends for polyclinics to offer specialized outpatient care after referral by a GP. Specialized services such as obstetrics/gynaecology and paediatrics, including "consultation centres for women and children", are integrated within the PHC system.

During recent years, a significant number of private specialized outpatient services have appeared, mainly in urban areas. Most of them offer high-technology diagnostic and treatment services and boast excellent infrastructure. It is difficult to get information about the number of these facilities and the volume of services they provide. However, these services are not covered by any form of insurance, and consequently they are not financially accessible to poor people or members of other marginalized and vulnerable groups.

Hospital services have gone through difficult times during the last ten years. They were targeted by armed gangs and individuals during the civil disturbances of 1991–1992 and 1997, and various facilities were looted and damaged. In addition, they have had to cope with unusually heavy workloads. For instance, from March to August 1997, which was a period of widespread lawlessness, hospitals reported more than 2000 people dead and 11 000 wounded to the Ministry of Health *(20)*. Moreover, they had to cope with extraordinary emergency conditions when the Kosovan refugees poured into Albania in 1999. Public hospitals were used as shelters, with refugees occupying about 30% of hospital beds at the height of the crisis. Many of them were chronically ill people who could not be discharged to the difficult refugee camp conditions *(20)*.

Taking into account these unfortunate circumstances, as well as the obsolete hospital infrastructure inherited from the Communist regime, it is not surprising

that the hospitals are in poor condition. The Ministry of Health, with support from international agencies and NGOs, surveyed hospital conditions between July and September 1999, immediately after the Kosovo refugee crisis *(38)*. The report described "a sick hospital system in a sick economy" suffering many severe problems. The infrastructure was obsolete and the management inadequate. Of the 41 hospitals surveyed, 25% had less than 5 hours of running water. Only 45% of hospitals had continuous electrical supplies, while 5% of them had electricity less than 12 hours a day. Of the buildings, 34% were assessed in poor condition and only 25% in good condition, while the heating system in 84% of the facilities did not function satisfactorily *(38)*.

Much of the hospital rehabilitation and renovation work began in the aftermath of the refugee crisis. Of the US $130 million donated for health care services, US $102 million was targeted for secondary and tertiary inpatient and outpatient care. This figure included US $68 million for hospitals in Tirana, 18% of which was for tertiary care *(20)*.

Tertiary care

Tertiary care remains quite limited in Albania and is located mainly in Tirana. It is provided by the following facilities:

- Tirana University Hospital (also called Mother Tereza), with around 1600 beds the biggest hospital in the country, offering secondary and tertiary care;
- Tirana Obstetric and Gynaecology Hospital, offering secondary and tertiary care;
- Lung Disease Hospital, offering secondary and tertiary care and long-term treatment for tuberculosis patients; and
- The Military Hospital, under the Ministry of Defence, specializing in traumatology and containing the university orthopaedic department.

The Ministry of Health has started an important programme of investment in the Tirana University Hospital. The government has already allocated a substantial amount of funds for the rehabilitation of various inpatient services. The World Bank plan to invest some US $11 million for restructuring the existing hospital (Health 2 Project) was changed in September 2002 and the money reallocated to other activities; the reason was the lack of capacity of the Ministry of Health and the University Hospital to implement the project. As noted earlier, the World Bank has also proposed helping the government develop a comprehensive regional master plan for the health care delivery system in

Tirana, covering all the services under the TRHA and their relationships to the hospital system. The Government of France has already started investing about US $6 million for the construction of a new building housing otorhinolaryngology, ophthalmology and maxillofacial surgery departments. The Government of Germany has allocated funds to renovate the infrastructure of the paediatric services, while the Government of Japan is expected to contribute about US $5 million to equip them. The International Organization for Migration (IOM) invested in the haemodialysis service, increasing its dialysis capacity from 25 to 50 patients per year. IOM is also renovating the infrastructure and equipment of the cardiac surgery services. All these investments are being carried out according to the Tirana University Hospital master plan, which was prepared with help from the Assistance Publique des Hôpitaux de Paris in 1997 *(24)*.

Despite the immediate positive impact of these major works, a big question remains: will Albania be able to afford, in the short- to medium-term, the additional operational costs generated by these substantial investments?

Social care

In 1999, only 5.8% of the population was aged 65 years and over. In addition to the elderly, other vulnerable and risk groups also need the special attention and care that basic social services can provide. They include mentally and physically disabled people, children and youth at risk, women and families at risk, etc. People with disabilities who were receiving social assistance benefits numbered 22 900 in June 1997, but this figure is considered an underestimate *(39)*.

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 policy 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 the patients are isolated from their families. Some district hospitals also have psychiatric wards, but they treat only acute cases. There are also some centres for people with learning disabilities, which are managed by various NGOs and the Ministry of Labour and Social Care.

In addition, there are beds in spas, or balnearies, but they are not considered part of the health care system.

So although a few Albanian institutions do provide social care, most people rely upon their families for it. Rehabilitation services and home support services (such as home nursing) remain very underdeveloped. In the last few years, the first groups of social workers have graduated from the University of Tirana, having received instructional support from various foreign universities. The profession is new to Albania, and most social workers work for the NGOs that have recently started social care activities in the country.

A study assessing vulnerable groups and social services concluded that these services are completely missing at the community level. The existing services have limited capacity compared to the demand, and consequently, people are being excluded who would benefit from them. Moreover, the services are not comprehensive, and they do not combine rehabilitation and therapy with information, prevention and integration. Finally, their geographical coverage is inadequate, leaving out many of the rural areas and isolated communities that make up most of the country *(39).* In 2001, a US $15 million initiative from the World Bank, the Social Services Delivery Project, began to address some of these pressing issues.

Human resources and training

For the size of its population, Albania has few trained health care professionals in comparison to other European countries. Furthermore, the distribution of health care professionals remains concentrated in hospitals, a problem Albania shares with most of the other countries with ex-Soviet model health care systems. In 1999, the public health care sector employed 25 670 people, a drop of 27% from 1991 *(12).*

In the same year, the private health care sector employed 2954 professionals, or about 11.5% of the health care total. The private sector is concentrated primarily in dentistry and the private pharmacy network. About 80% of all dentists and pharmacists operate in private facilities *(40).*

The internal distribution of health personnel remains a critical issue for the Ministry of Health. It seems that hospitals in general are overstaffed for the type and volume of services they provide. In addition, there are large disparities in staff distribution among different districts. These imbalances are chiefly due to the difficult living and working conditions in remote rural areas that are already deserted by medical personnel. Internal migration from rural to urban areas is another factor. However, the issue of personnel distribution is complex, and finding solutions is a challenge for many developing countries.

Albania is also experiencing a severe brain drain. According to some sources, during the period 1990–1999, 40% of the professors and researchers at Albanian universities and research centres left the country. A 1999 survey showed that 67% of the 300 academics who had obtained a Ph.D. in a western country during the 1980s and 1990s had already emigrated *(5).* There are no data on how many medical academics and researchers left Albania during this period, but it is probable that they too form a substantial part of this exodus.[7]

According to a draft document produced by the Ministry of Health Department of Human Resources, the sector's main personnel problems include *(40):*

- imbalances in the geographical distribution of staff and in the mix staff and skills
- differences in knowledge and skills among different types of staff
- out-of-date job descriptions
- limited staff development and absence of carrier plans
- severe shortages of trained supervisory and managerial staff
- low levels of individual and organizational productivity.

The Ministry of Health, through its Department of Human Resources and district health teams, recognizes the need to devise effective personnel policies in collaboration with professional bodies such as the Order of Physicians and nursing organizations. However, at present these organizations have only limited experience in human resource policy-making and planning.

Albania had 4494 doctors in 1999, or 1.36 doctors per 1000 population. Of them 1532, or 34%, were PHC physicians. As Fig. 10 shows, Albania and Turkey have the lowest population density of physicians among all the countries in the European Region. As can be seen in Fig. 11 and Table 16, the concentration of doctors in the population was roughly constant in the five years after 1994. Yet both Table 16 and Table 17 indicate that numbers of graduating physicians have fallen to roughly half in the same six-year period. The number of graduating dentists is also falling rapidly, while pharmacist numbers are declining at a slower rate.

The total number of nurses and midwives amounts to 3.7 (Fig. 10) or nearly 4.0 (Table 16) per 1000 population.[8] This figure is one of the lowest in the entire European Region. Table 16 and Fig.12 show that the number of nurses has been falling since 1994.

[7] This trend, it should be pointed out, applies to academics and researchers and not to practising doctors, as the number of doctors in the population has remained roughly constant (see the following paragraphs).
[8] The discrepancy between the Albanian statistics (Table 16) and the health for all numbers (Fig. 10) is due to differences in classifying health care personnel.

Table 16. Health care personnel, 1994–1999 (per 1000 population)

	1994	1995	1996	1997	1998	1999
Physicians	1.32	1.32	1.33	1.34	1.35	1.36
Dentists	0.39	0.39	0.41	0.40	0.41	0.34
Certified nurses and midwives	4.47	4.40	4.35	3.82	3.77	3.97
Pharmacists	0.29	0.29	0.30	0.30	0.30	0.28
Physicians graduating	0.11	0.10	0.10	0.10	0.09	0.05
Nurses graduating	–	–	–	–	–	–

Source: INSTAT, 2001 & Ministry of Health Statistics Unit.

Medical training

Doctors are trained by the Faculty of Medicine at the University of Tirana. Since 1992, admission has been on a competitive basis, with the numbers of students determined by the government. Six years of study are required to obtain the medical degree, and about 200 medical students graduate each year, including dentists and pharmacists (Table 17). There is a competitive exam that one must pass to enter specialist training, and most training takes three to four years. There is a bias towards medical specialization, which until the mid-1990s was not standardized across educational institutions.

Table 17. Students graduating from the Faculty of Medicine, University of Tirana, 1994–2000

	1994	1995	1996	1997	1998	1999	2000
Medical doctors	361	349	345	336	293	153	150
Dentists	54	8	54	57	44	27	32
Pharmacists	38	8	36	39	30	19	32
Total	453	365	435	432	367	199	214

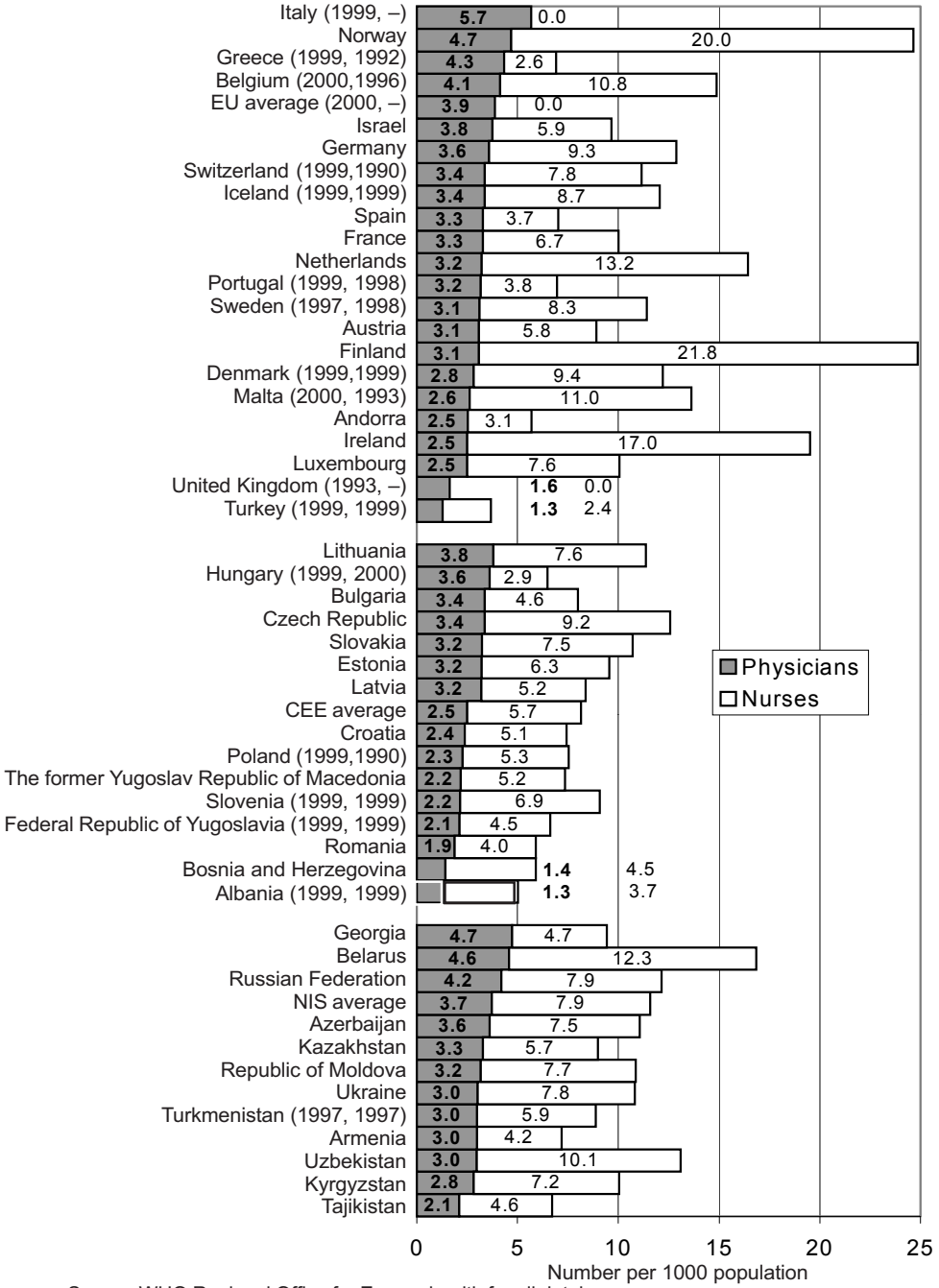
Source: INSTAT.

Before 1997, there was no training in general practice. Since then, GPs are being trained in a new two-year postgraduate course in general practice at the University of Tirana. General practice is one of the least popular postgraduate courses for young doctors.

Albania has no professional accreditation system for physicians, and no provisions for continuing medical education.

The Order of Physicians, created in 1993, is responsible for registration and professional standards, but it is extremely rare for doctors to have their licence revoked. The order needs to strengthen its role in promoting professional ethics and advising on professional education and standards of practice. The DFID and the GMC have been offering assistance in these areas.

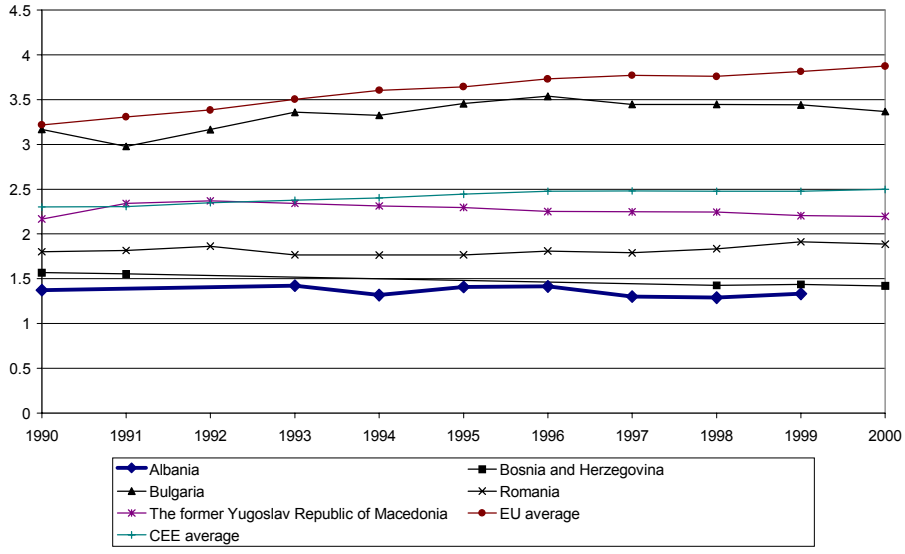
Fig. 10. Number of physicians and nurses per 1000 population in the WHO European Region, 2000 or latest available year (in parentheses)



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

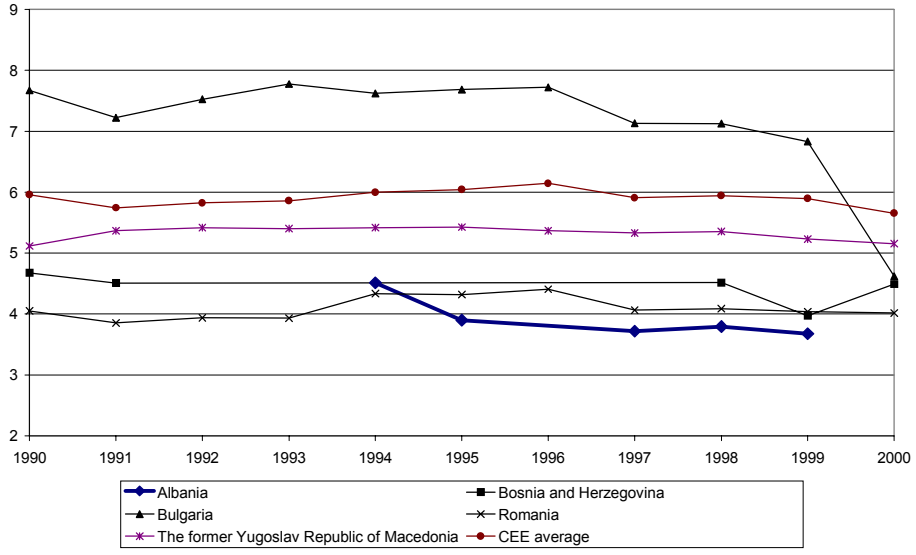
CEE: central and eastern Europe; EU: European Union; NIS: Newly independent states.

Fig. 11. Physicians per 1000 population in Albania and selected countries



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

Fig. 12. Nurses per 1000 population in Albania and selected countries



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

Nurse training

Before the Second World War, no nurses were trained in professional schools in Albania. Then nurses' training was offered as both a two-year and four-year programme at the high school level. Apart from general nursing and midwifery, there was little formal specialization, and any additional training was conducted by the employer.

Nurse education has now moved on to post-secondary colleges. 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. Other colleges have opened in Elbasan and Korce. Nurses are also being trained to teach in these post-secondary programmes.

The Nurses Association was established in the late 1990s, but the professional regulation of nurses in Albania still has a long way to go.

Nurses' salaries, like those of all health professionals in the country, are very low, which has an adverse effect upon their motivation and morale. In comparison with physicians, nurses in Albania are often treated as second-class citizens. Upgrading nurse education to the university level and involving nurses in the teaching process is expected to bring positive changes in this regard. However, Albanian nurses are strongly attracted by prospects in western Europe, and those with a university degree are leaving the country in very large numbers, primarily to take jobs in the Italian health care system, which recognizes their diplomas.

Other training

Albania has a shortage of personnel with knowledge and technical skills in medical research, health care policy and health administration. There are not enough technicians (bioengineers) to manage medical technology. There are no nonmedical professionals, such as health economists or health promotion specialists.

Some medical practitioners also need training in health systems management. There is no tradition of health sector management in Albania, and hospital directors are usually doctors with no management training. After piloting six short-term training courses in 1998, the World Bank and the Ministry of Health launched a five-month training course in health planning and management for district teams, focusing on primary health care. The course received technical support from the University of Montreal, and it was offered three times in the period 2000–2002. The Faculty of Medicine has already started offering a post-graduate training course in public health, and it is also planning to develop a postgraduate diploma in health administration.

The Ministry of Health and some foreign experts produced a document in March 2001, highlighting some of the main problems relating to the poor performance of the country's health system. The report identified "low level of individual professional competency" as one of the primary reasons for the poor results, and attributed it to inadequate training of physicians, nurses and technicians, as well as inadequate licensing and certification procedures. The report also attributed some of the system's poor performance to an absence of positive incentives and a lack of management training and experience *(41)*.

Pharmaceuticals and health care technology assessment

In 1992, the two state pharmaceutical manufacturers, Profarma and the Antibiotics Factory, were on the verge of collapse and lacked money to buy imported raw materials for production. Albania received some foreign aid to address the situation and began discussions on privatizing all or part of the industry. Both of the manufacturers have now been privatized. There are also a few small pharmaceutical companies that produce a limited number of drugs and cosmetics.

These domestic manufacturers produce a number of essential drugs. There has been an increase in imported drugs, however, which are more expensive for consumers. Pharmaceuticals must be registered with the Ministry of Health before they can be sold in the country.

Pharmaceuticals account for a high proportion of health service expenditures in most former Communist countries, where they are now a high priority in health care reform. In 1994, they accounted for 23% of health care spending in Albania; in 1999, this figure was estimated at 25%, or 3 780 million leks.

A national pharmaceuticals policy, drawn up in 1993, has been partially implemented over the last few years. It contains a number of goals such as the establishment of good manufacturing practice, the compilation of a national formulary and the periodic updating and expansion of an essential drugs list.

In 1994, an essential drugs list of 174 products was drawn up, adapted from the WHO Essential Drugs List. Only the pharmaceuticals on this list are reimbursed, either in part or in full, by the HII. The list was expanded to 278 drugs in 1997, and to 308 drugs in 2001. Drug reimbursement absorbed 70%

of the HII budget in 2000 (Table 9), when it had reimbursement contracts with 754 pharmacies and pharmaceutical posts.[9]

As of December 2000, only infants under one year old, invalids and war veterans received full subsidies for essential pharmaceuticals. Other subsidies are categorized by therapeutic application, for example, drugs used for cancer or tuberculosis. Full subsidies account for about 31% of all HII drug expenditures.

Hospitals purchase essential drugs three months in advance based on anticipated need. As funding is very limited, they often run out of drugs before new supplies arrive, so that patients must often buy their medications from private pharmacies. Drug reimbursement by the HII is not indexed to price changes and inflation, so that pharmacists pass on such additional costs to consumers.

Private pharmacies, which number more than 500, are well stocked and better managed than hospital dispensaries. There is no shortage of essential drugs, but the absence of a good regulatory framework allows poor practices to continue, such as the dispensing of drugs that are 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.There are various policy proposals to improve the cost–effectiveness of pharmaceutical use. One proposal, for health care facilities to be responsible for purchasing consumables and drugs from their own devolved budgets, has now been implemented. Another proposal would require prescription training for medical personnel, so that they can both prescribe the most effective drugs and control costs. As part of a third proposal, the Ministry of Health is developing standard treatment protocols with technical assistance from the World Bank.

Until 1992, Albania produced all the vaccines used in its national immunization programmein the Institute of Hygiene, Epidemiology and Immune-biological Products, except for the poliomyelitis vaccine. Production took place under poor laboratory conditions, which was why the Ministry of Health decided to stop producing vaccines. Since then, all vaccines have been supplied by UNICEF or imported. However, quality control of imported biological products and drugs remains a problem, since Albania has poor quality control capabilities.

Health care technology assessment is an area that still needs to be developed. One proposal, which has not yet been implemented, is to only purchase

[9] A pharmaceutical post (or agency) is a small unit attached to a health centre, usually in a remote rural area, that distributes a limited number of essential drugs. In most cases, it is staffed not by pharmacists but by other health care personnel who are permitted to dispense drugs.

expensive technology after assessment by an expert national body. There is also an urgent need to oversee the safe operation and proper maintenance of basic medical equipment (X-rays, laboratory equipment, etc.).

Financial resource allocation

Third-party budget setting and resource allocation

The financial allocation mechanism in Albania before 1990 was discretionary. Funds were allocated to institutions and districts on the basis of their historical budgets (using line items such as salaries) and political factors, rather than according to a needs-based or output-based formula. There was no incentive for good financial management and little autonomy, since funds were strictly earmarked. Hospital directors and physicians were obliged to make frequent visits to the Ministry of Health and the MoF to argue their cases for funds and staff *(19)*.

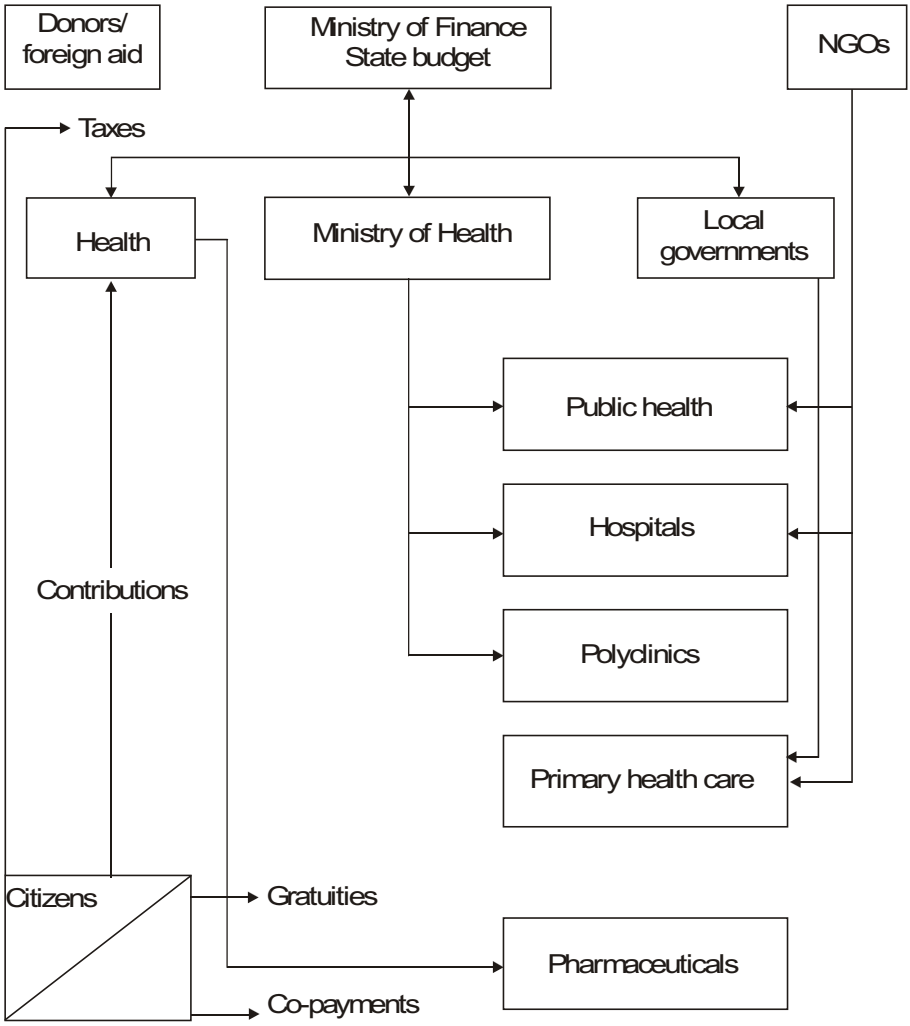
An annual budget is now agreed upon and ratified by Parliament at the start of the financial year. Funds are then allocated to the Ministry of Health, local governments and other bodies. There is no real separation of purchasing from provision. In the two pilot projects described elsewhere, the HII is starting 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, which is particularly pronounced at the primary care level. It is impossible to design an effective performance-based incentive system for PHC when the HII 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

Fig. 13. Financial flow chart of the health care system



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, including the infrastructure, operational expenses and nurse and midwife salaries. They receive the majority of their funds from the state.

The HII is playing an increasing role in financing health care provision. PHC doctors are now paid by the HII, and there is a major policy proposal to

expand the scope of the insurance fund, first by funding all PHC, then specialist outpatient care and finally hospital inpatient care.

A second major proposal is to establish regional health boards. They would consist of representatives from local governments, local health teams, the Ministry of Health, the MoF and the HII. Each board would be charged with planning and allocating the resources of one prefecture. A pilot project has started in the Tirana Prefecture, with financial support from the World Bank and technical assistance from the DFID Know How Fund. At present, however, there are considerable legal obstacles to changing the centrally controlled line item accounting system.

A third proposal would make the managers of health care facilities more autonomous by giving them the authority to reallocate resources, control service quality and devise incentive schemes. The HII has begun a pilot with a case-mix budget system in the Durres regional hospital in order to explore the model's advantages and disadvantages. The Ministry of Health considers financing hospitals with the Health Insurance Fund to be a medium- to long-term strategy goal.

The IPH is funded by a separate Ministry of Health budget line, as are the other national institutes.

Payment of physicians

The Health Insurance Fund has paid the salaries of PHC physicians since 1995. Each salary is based on a capitation amount for the number of patients enrolled in their practice, with some weighting for geographic area and types of patients. The capitation system is being gradually expanded, and the pilot scheme in Tirana has started funding other PHC salaries from the insurance fund. By the end of 2000, the HII was paying capitation fees to 1512 GPs in 564 health centres and urban clinics *(27)*.

Other physicians' salaries are based on national pay scales. Many physicians also receive under-the-table payments from patients, but the extent of these payments is not known. Except for professors in the Faculty of Medicine, physicians are not allowed to work in the public sector and private clinics at the same time.

Remuneration for doctors is generally low and remains a major source of contention. However, it is said that PHC physicians paid by the HII have increased their incomes by more than 50% since the establishment of the insurance scheme. In 2000, according to the HII, the average monthly salary

for GPs was 29 000 leks, or about US $210. They now receive higher payment than some specialists on the national pay scale. Recently, the government also introduced a 12% salary increase for health care staff, with a higher compensation rate for rural staff, but remuneration needs to be increased still further to discourage under-the-table payments.

Health care reforms

Aims and objectives

When Albania began the transition from a centrally planned to a market economy in the early 1990s, it was the poorest country in the European Region and had a long history of isolation. The dissolution of the Communist model was accompanied by the collapse of its institutions, structures and mechanisms – which meant that new systems had to be developed. The health care system that emerged has faced great difficulties: severe budget constraints due to the shaky economy, disruption and damage caused by civil disturbances, and a population with urgent health needs.

The Ministry of Health presented its sector reform proposals in June 1993, in *A new policy for the health care sector in Albania.* This document was written in response to a World Bank paper published in March 1992, which highlighted some major health care reform strategies for the transition period *(42, 18)*.

The Ministry of Health identified two overarching objectives: first, prevent further deterioration of basic services; and second, transform the health care system into a financially sustainable system that can be managed efficiently and produce effective services *(42)*. The ministry also articulated several basic policy goals:

- to guarantee the population full access to all preventive and most curative care at an affordable price;
- to give priority to those forms of health care that offer the best chance of improving health at the lowest price;
- to base the health system on a PHC foundation;
- to introduce market elements into health care financing;

- to grant more managerial autonomy to districts and to create health care regions.

These objectives and goals were supported in turn by a number of more specific aims and proposed reforms.

- *Streamline health service*s by maintaining and rationalizing the network of PHC facilities, transforming rural hospitals into outpatient health centres, maintaining the network of district hospitals that offer the four basic health care services, upgrading a few district hospitals to regional hospitals with 10–12 specialized services and reorganizing national facilities to form a unified university hospital.
- *Improve the quality of health services* by rehabilitating infrastructure, renovating and standardizing equipment, introducing a general practice service and allowing patients to choose their own doctors.
- *Protect and increase financial resources* by protecting and increasing the health care budget; legalizing private services, particularly dentistry, drug distribution and outpatient services in the short term, and hospital services in the medium term; carefully introducing a scheme of health insurance; and strengthening the regulatory capabilities wielded by the Ministry of Health and other organizations, such as the Order of Physicians.
- *Rationalize and develop human resources* by reducing surpluses in health sector personnel, reducing the number of medical students, reviewing the medical school curriculum, standardizing postgraduate training, upgrading nurses' basic training to a three-year university degree, initiating a system of regular continuing education for health workers, introducing postgraduate courses in general practice and introducing public health and health management.
- *Decentralize and regionalize health services.*
- *Implement a new pharmaceutical policy* by adopting a new formulary for drugs, establishing a drug registration and licensing procedure, privatizing the drug manufacturing industry, introducing subsidies for essential drugs in private pharmacies and improving the quality control of imported drugs.
- *Improve the compilation of health statistics and information.*
- *Expand public health outreach* by strengthening existing public health programmes, such as health education and promotion, MCH, and HIV/AIDS prevention and control; and by establishing new programmes in areas like family planning, hepatitis control and safe blood supply.

Many of these reform suggestions were implemented, giving rise in turn to a number of new difficulties and challenges. To further the reform process, in

September 1999 the Ministry of Health published *Albanian health system reform*, a position paper based on the lessons it had learned in implementing these suggestions. It was an important reform document, developed in close collaboration with WHO.

The position paper confirmed the Ministry of Health's commitment to reform. It took the ideas from the mid-decade reforms and developed them further, as well as putting some new elements on the Ministry of Health reform agenda. The paper identified three essential areas of health system reform and made a host of reform suggestions in each area *(22)*.

1. Reforming regulation:
   - Transform the Ministry of Health from an organization that manages and operates facilities into a policy-making and planning organization, as well as a national regulatory body able to perform accreditation, monitor quality control, standardize procedures and coordinate the interests of various stakeholders.
   - Redraw the institutional map of the health sector, to make its various institutions more responsive to the new challenges of Albanian society and the changing reality of its health care system. This proposal is primarily aimed at the IPH, the National Blood Centre, the National Directorate of Health Education and Promotion, etc.
   - Strengthen the role of professional organizations, especially the Order of Physicians and the Nurses Association.
   - Place the patient at the centre of the system by formulating a patient charter that advocates patient protection, freedom of choice and other principles.
   - Redefine the respective roles of the public and private health sectors. Treat private health services as supplementary to public ones, and monitor both for the quality of care they offer consumers.

2. Reforming health financing and resource allocation:
   - Procure sufficient and stable funding. Increase and protect the health budget, levy out-of-pocket fees, allocate resources more transparently and efficiently, and finally, fight corruption.
   - Combine solidarity and responsibility in health financing. The future health system will follow a Bismarck model, and the state budget must coexist with health insurance and out-of-pocket payments. Preserve and build up the Health Insurance Fund by strengthening the HII, giving it more autonomy and increasing compliance.

- Allocate resources according to health needs. Change current practice by introducing new allocation mechanisms to take equity criteria into account.
- Reform the system for paying hospitals. Give hospitals more autonomy in the areas of management, fundraising and personnel hiring and firing. Set up management boards and make financing a contract base prospective funding.
- Reform the system for paying doctors and other health professionals. Introduce more incentives and increase staff performance by paying employees based on hospital performance. In PHC, gradually introduce a scheme combining capitation with fee-for-service payments for certain activities.

3. Reforming health services production:
   - Improve the quality of services by introducing accreditation requirements, upgrading infrastructure and equipment, retraining personnel and establishing quality control mechanisms.
   - Introduce professional management into the system by developing appropriate information systems, outsourcing support services and attracting talented and well-trained managers.
   - Establish general practice as a discipline. The aim is to create PHC teams composed of well-trained GPs, nurses and other professionals capable of providing both preventive and curative care.
   - Reshape and improve other health sector services such as public health services, emergency systems, pharmaceutical distribution and dentistry.

Albanian health system reform was supposed to be followed by a strategy document and an action plan that would guide the next steps in the reform process. The Ministry of Health has formulated several drafts of these documents, but the government has not officially approved any of them.

Content of reform and legislation

Listed below are the chief Albanian laws and policy documents relating to health care reform since the collapse of the Communist regime *(43)*.

1992 Council of Ministers Decree No. 449, *Reorganization of the Health Services in State Enterprises*

1992 Law No. 7643, *On the State Sanitation Inspectorate*

1993 Law No. 7664, *On Environmental Protection*

1993 Law, *On Local Government* (regulates elections, responsibilities, functioning and relationship to the state)

1993 Law No. 7692, *On Fundamental Human Rights and Freedoms* (supplements the constitution)

1993 Law No. 7708, *On the Order of Physicians* (requires compulsory registration of physicians)

1993 *A new policy for the health care sector*, Ministry of Health policy document

1993 Law No. 7718, *On Health Care* (abolishes right to universal free health care)

1993 Council of Ministers Decree No. 325, *On the Import/Export and Wholesale Trade of Drugs and Medical Supplies*

1993 Minister of Health Order No. 165, *Guidelines on the Privatization of Dental Prosthetic Services and Optical Services*

1993 Law No. 7738, *On Health Care* (guidelines for payment of dental services and for health insurance scheme)

1993 Law No. 7761, *On Infectious Diseases*

1993 Law No. 7815, *On Drugs* (regulates drugs and reimbursement for essential drugs)

1994 Law No. 7835, *On Autopsies*

1994 Law No. 7850, *On Health Insurance* (reimbursement for drugs and GPs)

1994 Law No. 7941, *On Food* (assigns ministerial responsibilities for food quality and distribution)

1994 Law No. 7975, *On Narcotics and Psychiatric Drugs*

1994 Law No. 8025, *On Protection from Ionizing Radiation*

1994 Council of Ministers Decree No. 613, *On the Status of the Health Insurance Institute* (gives the HII autonomy)

1995 Council of Ministers Decree No. 343, *On Financial Coverage of General Practitioners by the Health Insurance Institute*

1995 Law No. 8032, *On Blood Donation, Transfusion and Control of Blood Products*

1995 Law No. 8045, *On Medical Interruption of Pregnancy* (establishes abortion criteria)

1996 Law No. 8092, *On Mental Health* (psychiatric care and patient rights)

1996 Law, *On Dental Health Services* (organization, functioning and practices in public and private dental care services)

1997 Law No. 8193, *On Organ Transplants* (regulates organ donation for transplant purposes)

1999 Law No. 8528, *On Promotion and Protection of Breast-Feeding*

1999 *Albania health system reform: a position paper on policy and strategies for Albanian health system reform,* Ministry of Health policy document

2000 Law, *On the Order of Physicians in the Republic of Albania* (modifies and updates Law No. 7708 (1993))

2000 Council of Ministers Decree No. 394, *On the Establishment, Organization and Functioning of the Tirana Regional Health Authority*

2000 Council of Ministers Decree No. 547, *On Health Insurance Financing of Primary Health Care Services in Tirana on a Pilot Basis*

2000 Council of Ministers Decree No. 560, *On Health Insurance Financing of Durres Hospital Services on a Pilot Basis*

2001 Council of Ministers decree, *On Integration of the National Directorate of Health Education and Promotion with the Institute of Public Health*

2001 Law No. 8689, *On AIDS Prevention and Control* (also deals with assistance to and rights of people infected with HIV)

2001 Law, *On Reproductive Health*

These laws can be grouped under four headings: diversification of financing, decentralization, health service reform and drug distribution.

Diversification of financing has been an essential component of Albania's health system reform. It has been made possible by a variety of measures, including the ones privatizing health services, introducing fees in the public sector and creating the Health Insurance Fund. In 1993, *On Health Care in the Popular Republic of Albania*, a law dated 17 December 1963, was abolished, and two new laws were passed. Law No. 7718, *On Health Care,* abolished the concept of universal free health care and paved the way for the introduction of private medical practice. Law No. 7738, which is also called *On Health Care,* provided a framework for regulating payment policies in the new private dental services and prepared the ground for the health insurance scheme. These new laws enabled the Minister of Health to issue orders introducing and regulating out-of-pocket payments for the provision of various health care services.

In 1994, Law No. 7850, *On Health Insurance,* established the health insurance system. It covered subsidies for essential drugs and GP fees. Moreover, the law left open the possibility of extending coverage to other health services. In 2000, two decrees by the Council of Ministers used this opening to give the HII responsibility for financing PHC services in Tirana Prefecture,

and a third to give it the responsibility for financing inpatient hospital services in the Durres Prefecture.

Decentralization has been considered by the government another essential area of reform, increasing citizens' participation in the decision-making process and strengthening democratic mechanisms. Decentralization started in 1993 with *On Local Government,* a law that granted the elected government of communes the control of all PHC services in rural areas. Then Law No. 7718, *On Health Care* (1993), delegated to the Minister of Health the right to restructure or create new health facilities. In 1993, a Minister of Health order restructured district health services by giving the Ministry of Health districts more power over resources.

The decentralization process went further in 2000 with a Council of Ministers decree creating the TRHA. Another decree financed the Durres regional hospital from the health insurance scheme, giving the facility more autonomy and creating another decentralization model.

The reform of health services is based on a variety of legislation. Most rural hospitals were transformed into outpatient PHC centres through an order of the Minister of Health in 1993. Five separate Tirana university hospitals were integrated under a single administration, leading to the creation of the Tirana University Hospital Centre.

Law No. 7708 (1993) created the Order of Physicians and introduced their compulsory registration process. This law was amended in 2000 to give the organization more autonomy.

Various legislative acts have addressed public health issues. Law No. 7761, *On Infectious Diseases*, introduced preventive and control measures adapted to the country's new political, economic and social realities. The purpose of the law was to create public health measures while protecting citizens' rights and abolishing coercive measures that lacked solid scientific grounds. This law was amended in 2000 by Law No. 8689, *On AIDS Prevention and Control*, a step forward in caring for and protecting the rights of HIV-positive people.

In 1995, Law No. 8032, *On Blood Donation, Transfusion and Control of Blood Products,* was passed to ensure the safety of the country's blood supply through obligatory blood screening and voluntary donations.

Law No. 8045, *On Medical Interruption of Pregnancy* (1995), improved abortion's legal framework with a liberal abortion policy, while Law No. 8092, *On Mental Health* (1996), established a framework to care for and protect the rights of psychiatric patients.

On Reproductive Health was approved in 2001, following a big media and public debate on artificial insemination. The law established rules for regulating this practice in Albania's changing society.

Drug distribution in Albania has also undergone significant change. Law No. 7718, *On Health Care* (1993), permitted private enterprises and pharmacies to distribute pharmaceuticals. The regulatory framework and requirements for pharmaceutical import and export were defined in the Council of Ministers Decree No. 325, *On the Import/Export and Wholesale Trade of Drugs and Medical Supplies* (1993). Additional regulatory measures were introduced through Law No. 7815, *On Drugs* (1993), including an obligatory drug registration system.

Reform implementation

The health sector reforms launched in 1993 were supported to a varying degree by different stakeholders, including government ministers, parliamentarians, health providers and citizens. Their support made it possible to implement successfully some key reforms:

- the privatization of pharmacies and dentistry services
- the introduction of private medical practice
- the autonomous health insurance fund managed by the HII
- the conversion of most rural hospitals to outpatient clinics
- the unification of national health care facilities as a single university hospital centre
- increased managerial autonomy for district health administrations
- subsidies for a national essential drugs list
- the creation of mechanisms for drug registration and licensing
- the establishment of postgraduate courses in general practice
- the upgrading of nurses' basic training to the university level
- the establishment of a family planning programme
- the introduction of mandatory vaccination against hepatitis B for all newborn babies
- the systematic testing of all blood donations for hepatitis B and C as well as HIV.

Many reforms, however, were implemented only partially or not at all. These failures were due to a variety of reasons, including the inadequacy of the

Ministry of Health and its units, resistance from interest groups and other political factors. In addition, the dramatic events of 1997 that brought Albania to the brink of civil war, the political crisis of 1998 and the Kosovo conflict of 1999 had a tremendous impact on all aspects of life in Albania and interrupted the reform of the health system. A number of reforms, therefore, were not carried out successfully.

- The Ministry of Health has not created a national map of district and regional hospitals.
- The regulatory framework for private health services has not been fully defined, and effective monitoring procedures for public services have not been established.
- Postgraduate training in health management, public health and general practice are facing difficulties.
- The continuing medical education courses launched by some donor agencies have not continued.
- Despite investment by the government and donors, health facility infrastructure and equipment remain substandard and the quality of service very poor.
- The country's governing and regulatory capabilities remain weak.
- Neither patients nor providers are satisfied with the present health system.

Despite such difficulties, the reform of the health care system is continuing. Among other things, health care funding will be further diversified, and the HII will play a more prominent role in funding direct service delivery. As mentioned above, the HII has started to purchase all PHC services in the Tirana region and expects to extend PHC purchasing to other districts.

There are also plans to change resource allocation within the health sector. Health insurance will also play a greater role in funding specialized outpatient care and hospitals, exemplified by the contract-based reimbursement system being piloted at the Durres regional hospital.

The Ministry of Health retains control of secondary and tertiary health care, so decentralization has been limited. The directors of health care facilities still have little autonomy and few incentives for more cost-effective management. However, the pilots in Durres and Tirana are expected to lead to more autonomy for hospitals and other health facilities.

Local authorities are expected to have limited control over the daily management of health services and their operational resources. Their planning and managerial capabilities are very weak and their accountability almost nonexistent. Regional and district health boards, with representatives from local

authorities, may be set up to advise on local policies and plans. A regional health authority was established in Tirana in 2000, and this model may be extended to the rest of the country.

Current health policies propose separating the regulation of the health care system from its financing and service delivery. For this purpose, the Ministry of Health has been starting to assume more of a policy-making and planning role, creating a policy and planning department in 2000. To carry out the separation, resource allocation decisions, except for major capital investments, would be transferred from the state to the HII and local health boards. Such a major change would require many political and legislative decisions.

Several fundamental barriers have made health system reform difficult in Albania.

- *Weak leadership*. The health sector is characterized by poor leadership. There is little policy vision on sector reform, and the rapid turnover of political and technical leaders in the Ministry of Health and its agencies results in considerable volatility. In addition, the Ministry of Health has little technical capacity to plan and implement reform programmes. Donors try to help Albanian decision-makers by taking the lead in the reform process and end up pushing their own agendas.
- *Lack of participatory policy-making*. In Albania, there is no tradition of participatory decision-making process, and the old model of command and control does not work any more. There is often strong resistance from various interest groups in the reform process because they have not been included in the policy formulation process – or because they do not agree with the proposed reform. For example, World Bank investment in the Tirana University Hospital was delayed for almost two years because of resistance from infectious disease doctors who opposed the restructuring strategy, which had already been agreed upon. A major cultural shift needs to take place in Albanian society in general and the health sector in particular. The government needs to elaborate mechanisms to involve all important stakeholders from the beginning of the decision-making process.
- *Lack of public communication*. The Ministry of Health needs people with expertise in communication strategies to explain the need for reform to the general public and other stakeholders. There is no public confidence in the health sector, and people do not believe that its administrators have the capacity and good will to make the necessary improvements. The Ministry of Health needs to develop mechanisms for communication and public relations campaigns.

- *Low priority*. Only recently have health sector issues been put higher on the government agenda. The increased visibility is due mainly to pressure from the donor community that assisted the government in preparing a poverty reduction and economic growth strategy *(9)*. Nevertheless, solving the serious problems of the health sector should be even higher on the Albanian political agenda.
- *Political instability and economic difficulties*. Reform of the health sector has been implemented in a context of political instability, consecutive and severe crises, and economic difficulties that include extreme poverty. In such a challenging environment, health system reform runs the risk of poorly thought-out initiatives and inadequate implementation.

Conclusions

Albania has embarked upon major health sector reforms, but it is greatly hampered by political instability and a struggling economy. Nevertheless, the population enjoys reasonable health according to key indicators such as life expectancy, a situation that is particularly impressive in a context of widespread poverty and very low spending on health care. However, continuing poverty and unhealthy new lifestyles introduced by rapidly changing socioeconomic conditions threaten Albanians' health in the medium to long term.

A prerequisite for any well-functioning health care system is peace and stability. Moreover, the state must have sufficient economic means to take responsibility for health care. To judge Albania's health care system fairly, one must keep in mind its low level of economic development and absence of long-term stability.

The Ministry of Health has yet to assume a strong policy and planning role, a role that is crucial if the country is to manage the increasing demands being made on its under-resourced health care system. In addition, health issues must be given a higher priority in the government's political agenda in order to strengthen the health care system and successfully carry out its reform.

Health care spending is very low and must be increased if services are to improve. Such an increase is strongly linked to the country's economic and social development. The health insurance system has been a relative success, with the fund showing a surplus in its initial years of operation. However, some groups, including farmers and, to a lesser extent, other self-employed groups, are not making insurance contributions, which impairs the equity of health care financing. The lack of a broad contribution base and difficulties in collecting payroll taxes (which include insurance contributions) may impede

plans to finance more health care through insurance. In addition, the growing proportion of private expenditures for health care through out-of-pocket payments further detracts from health care equity and access.

Privatization of the drug distribution system has improved drug availability. The introduction of subsidies for essential drugs has given the poorest segment of the population better access to drugs. However, access to health services remains an important issue for the Albanian health system due to internal migration and shortages of health personnel in rural areas.

The relatively slow pace of change in the financing and organization of health care has helped preserve some stability in difficult times. The Ministry of Health has proceeded with some rationalization of the hospital sector, which is likely to improve efficiency. Further improvements in efficiency will require the development of managerial skills by training regional, district and hospital administrators, and the devolution of more budgetary responsibility to regions and to hospitals. Management needs to be decentralized to improve accountability, but first, managerial competencies need to be developed at every level.

The emphasis on retraining health professionals and the move towards a GP system are positive developments that should improve the quality of care. Health care services are greatly hampered, however, by outdated equipment, inadequate drug supplies in public hospitals and poorly paid staff with low morale. Consumer choice is inevitably restricted, given the country's economic circumstances, but the prospect of being able to choose a GP is a step in the right direction.

It can be difficult to judge the effect of health care reforms on health. For instance, the liberalization of abortion has decreased the maternal mortality rate, but the number of abortions has increased dramatically since family planning services have yet to be developed. Similarly, the public health system is relatively effective, but it still lacks the flexibility to respond to rapid lifestyle changes that affect morbidity and mortality. Accidents and injuries are becoming a significant cause of mortality, while the epidemic outbreaks of recent years have shown the country's vulnerability to traditional threats.

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

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The health care systems in transition (HiT) country profiles provide an analytical description of each health care system and of reform initiatives in progress or under development. They aim to provide relevant comparative information to support policy-makers and analysts in the development of health care systems and reforms in the countries of the European Region and beyond. The HiT profiles are building blocks that can be used:

- to learn in detail about different approaches to the financing, organization and delivery of health care services;
- to describe accurately the process, content and implementation of health care reform programmes;
- to highlight common challenges and areas that require more in-depth analysis; and
- to provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in countries of the WHO European Region.

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