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ALBANIA HEALTH SECTOR NOTE

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Abbreviations and Acronyms

AIDS	Acquired Immunodeficiency Syndrome	MDGs	Millennium Development Goals
cGMP	Current Good Manufacturing Practice	MICS	Multiple Indicators Survey
CIF	Cost, Insurance and Freight	MMR	Maternal Mortality Ratio
CIS	Commonwealth of Independent States	MOE	Ministry of Education
ECA	Europe and Central Asia	MOH	Ministry of Health
EFPIA	European Federation of Pharmaceutical Industry Associations	NCD	Noncommunicable Disease
EMEA	European Agency for Evaluation of Medicinal Products	NCDC	National Center for Drugs Control
EPI	Epimastigote	NIS	National Immunization Program
EU	European Union	NSSED	National Strategy for Socio Economic Development
FDA	Food and Drug Administration	OECD	Organization for Economic Co-operation and Development
GAVI	Global Alliance for Vaccines and Immunization	PHC	Primary Health Care
GDP	Gross Domestic Product	RHS	Reproductive Health Survey
GP	General Practitioner	SEE	South East Europe
HALE	Health Adjusted Life Expectancy	STD	Sexually Transmitted Disease
HFA	Health For All	STIs	Sexually Transmitted Infections
HIF	Health Insurance Fund	TB	Tuberculosis
HII	Health Insurance Institute	UNDP	United Nations Development Programme
HIV	Human Immunodeficiency Virus	UNFPA	United Nations Population Fund
HR	Human Resources	UNICEF	United Nations Children's Fund
INSTAT	Institute of Statistics	USAID	United States Agency for International Development
IPH	Institute of Public Health	WDI	World Development Indicators
LSMS	Living Standards Measurement Survey	WHO	World Health Organization

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MAIN FINDINGS AND RECOMMENDATIONS

A. THE HERITAGE

1. **Albania's health care system prior to the transition was characterized by strong central government control over all aspects of the system.** Despite a widespread primary care network, which had been established with a focus on antenatal care and immunization, Albania's pre-transition health care system was largely led by secondary care. The system was highly centralized, with the Ministry of Health providing and regulating all health services in the country and deciding on resource allocation and the nomination of health care staff. The construction of new facilities was favored over the maintenance and operation of existing infrastructure, which led to considerable deterioration in facilities and equipment. Inadequate recurrent expenditures, obsolete drug therapies, and outdated medical skills resulted in low quality of care and inefficient use of resources.

2. **Civil unrest and the Kosovo crisis took a heavy toll on the health care system during the 1990s.** The violence and civil unrest during the early transition years and again in 1997 resulted in extensive damage to the health care infrastructure and in the disruption of essential services, including immunization, surveillance, and environmental health programs, such as water quality and waste removal. Almost one third of the country's medical staff abandoned their posts during the 1997 unrest. The Kosovo crisis in 1999 put additional strains on the system, as over 4,000 refugees were admitted to hospitals, while others were provided accommodation in hospitals for want of other shelter. The crisis caused further damage, consumed a significant amount of resources, and brought to a halt nascent structural reforms in the sector.

3. **A series of sectoral reforms were initiated in the mid-1990s, but limited progress has been made over the past 5 years in advancing these reforms.** While focusing on re-establishing services following the events of the early- and mid-1990s, the Government also initiated a series of reforms to begin to address some of the sector's weaknesses in the mid-1990s. The reforms included some reduction in the overextended provider network capacity, the decentralization of primary care management to district public health directorates and integration of the former with public health functions, the privatization of the pharmaceutical sector and most dental care, and the establishment of the Health Insurance Institute (HII), in view of a gradual aspired change of the health financing system. Plans were also made to substantially upgrade the quality of the primary care system through physical investments and skills upgrading. The Kosovo crisis interrupted many of these initiatives, and limited progress has been made in most of the reform areas since then. Some pilot projects on the provider organization and financing front were initiated over the past 4 years, which have yielded valuable lessons. More recently, encouraging progress has been made on pharmaceutical policy issues.

B. HEALTH OUTCOMES AND HEALTH CHALLENGES

Albania's health outcomes compare favorably with those of lower middle income countries outside the Europe and Central Asia region, but lag behind those of other countries in the South East European region.

4. **Despite progress achieved, Albania's health outcomes lag behind those of other countries in the South East European region.** While all sources show an improvement in key health outcome indicators over the past decade, different data sources paint a different picture as to how well Albania is faring compared to other countries in the region. By most accounts, Albania's health outcomes compare

relatively favorably to those of other lower middle-income countries outside the Europe and Central Asia (ECA) Region, but not to other lower middle-income countries in the South East European (SEE) region. On the basis of official data, Albania enjoys the longest life expectancy in the Balkans -- just 2 years below the EU average. Other sources put Albania's life expectancy below that of all other countries in the SEE Region, and 8 years below the EU average. Albania has the lowest healthy life expectancy in the SEE Region. Similarly, estimated data, which correct for expected underreporting, put Albania behind other countries in SEE regarding infant mortality.

5. Albania's demographic and epidemiological profile is changing. The relative burden of infectious diseases is decreasing while noncommunicable diseases have become the leading cause of death among the adult population. Infectious diseases are still a leading cause of infant and child deaths, but they are no longer a major cause of mortality among adults. Although HIV/AIDS prevalence is reportedly still low, the risk of HIV transmission is high, owing to mobility of the population and human and drug trafficking. Noncommunicable diseases, mainly cardiovascular diseases and cancer, have become the leading cause of death among adults. The incidence of these diseases is expected to increase substantially as the population over 65 years of age doubles in the next 20 years. Some studies suggest that the diabetes incidence rate is higher than in many Western European countries and likely to grow substantially over the coming two decades. Among the top new health risk factors are the high tobacco consumption, the rapidly increasing rate of fatal road accidents, and changing diets. The health care system is ill prepared to face the increase of noncommunicable diseases and the lengthy and costly treatment associated with them.

Albania's health care system is ill prepared to face the growing incidence of noncommunicable diseases and other new health risks.

6. A significant portion of chronic disease conditions could be prevented through the promotion of healthy lifestyles, screening, and primary and secondary preventive care measures. Increased focus on preventive health care is therefore becoming a pressing need in Albania. The capacity for health promotion and for primary and secondary prevention for cardiovascular diseases and cancer requires significant strengthening. This will require aggressive efforts to build up the capacity of primary care providers to adequately assess patient risk factors and to effectively manage the conditions of those exhibiting such risks. Concerted efforts are also required to improve Albania's health promotion capacity, so as to inform the population about new health risk factors and ways to avert them. Addressing these factors requires inter-sectoral coordination and outreach to the local community, in addition to the strengthening of the surveillance system. The Institute of Public Health is well placed to play a leading role in these efforts, but its capacity will require further strengthening and the resources allocated to public health issues, including health promotion and new public health initiatives, as well as health information, need to be increased to effectively address these challenges.

C. HEALTH CARE DELIVERY

Physical and human resources in the sector are ill aligned with the population's health needs.

7. A review of the distribution of physical and human resource capacity in the health sector points to large variations in coverage across districts and regions. The significant internal and out-migration in Albania over the past 15 years, combined with the massive destruction of facilities during the 1990s, has left an already imbalanced health care provider network further out of line with the population's health needs. The distribution of physical and human resource capacity in the sector remains uneven across regions, as well as within regions. While substantial efforts have gone into rehabilitating primary care facilities following the widespread destruction during the early- and mid-1990s, these efforts

appear to have been made without any thorough analysis of population needs and the suitability of proposed facilities in a given area. Similarly, investments in hospital facilities continue to be made without a clear hospital map in mind, often leading to opportunistic investment decisions, which contribute little to much needed consolidation and efficiency improvements in the sector.

8. There are marked regional imbalances in medical personnel coverage. Regional variations are highest for specialists and pharmacists and lowest, though still considerable, for primary care physicians. The relatively lower variation in general practitioner coverage appears to reflect concerted Government efforts to rebalance the ratio of general practitioners versus specialists, to substantially upgrade salaries for general practitioners, and, most importantly, to allow for considerably higher salaries for general practitioners serving in the more remote rural areas. There are also imbalances in terms of hospital versus primary care medical staff, and the ratio of doctors to nurses is high by international standards. There is considerable scope for substituting nursing time for physician time and clerical staff for nursing staff in hospitals in the medium to longer term. The skewed geographic distribution of health sector staff will need to be corrected over time, as part of an overall planning exercise for health sector human resources.

Productivity in the health sector is low and resources are used inefficiently.

9. Productivity is low, both for primary and hospital care, and it varies substantially across regions and individual facilities. Administrative data suggest that Albanians have significantly less outpatient contracts with health care providers than people from other countries in Eastern Europe and Central Asia, Latin America and the Caribbean, or Western Europe. Due to low perceived quality, bypassing of primary care in favor of seeking care at polyclinics or hospital outpatient facilities is widespread even for simple conditions like a cold or a flu. This leads to low utilization of primary care facilities and extremely low productivity of primary care staff. On average, a primary care doctor sees only about eight patients per day, with marked regional variations resulting in as few as three visits per day in certain regions. Analysis of primary care activity in Tirana region further points to substantial inter-facility variation in productivity. The gatekeeper role that general practitioners (GPs) are expected to play is not functioning, even though the MOH has introduced a fee system, which would require payment for care by all those who seek outpatient care directly at a polyclinic or at the hospital. The fee structure, however, is such that it provides the estimated 60 percent of the population without a health insurance card with little incentive to see a primary care physician, particularly if it is felt that the physician will be unable to provide the expected care. Experience in other transition countries and initial evidence from recent pilot activities in Albania suggest that productivity of primary care providers, particularly in rural areas, can substantially improve if they are provided with skills upgrading to offer a more comprehensive population-centered set of services and have access to adequate supplies and equipment.

10. A large number of small hospitals with low utilization and occupancy rates point to a sub-optimal hospital structure. While low compared to European averages, Albania's hospital capacity (3.03 beds per 1,000 population) compares favorably to that of many other lower middle income countries and is similar to that of Spain and Turkey. However, the configuration of the hospital network points to large inefficiencies. Over 60 percent of Albania's hospitals are too small to exploit scale economies in the general acute care hospital setting. Thirty out of 46 hospitals have less than 200 beds and jointly account for only one quarter of all hospital admissions, while they continue to consume a considerable amount of scarce resources. Low admission and occupancy rates lead to high staff per occupied bed ratios in the smaller hospitals and raise serious concerns about fixed costs, ineffective utilization of limited resources, and quality assurance. Several hospitals exhibit an oversupply of identical departments that could be merged, thus allowing for substantial efficiency gains. Hospital managers have neither incentives nor authority to undertake changes to improve the efficiency and quality of their operation.

Table 1 - Distribution of Hospitals and Utilization, by Number of Beds, 2003

Bed range	MOH Hospitals		Beds		Admissions		Bed occup rate	ALOS
	Total	In %	Total	In %	Total	In %		
< 49 beds	11	23.9	331	3.7	5,392	2.0	26.7	6.7
50 – 99	9	19.6	728	8.0	16,000	6.0	34.5	5.6
100 -199	10	21.7	1,386	15.3	44,438	16.5	47.8	5.9
200 - 299	7	15.2	1,774	19.6	59,064	22.0	67.5	35.8 (*)
300 - 399	3	6.5	1,072	11.8	27,331	10.2	53.5	76.0 (*)
400 - 499	3	6.5	1,236	13.7	37,232	13.9	39.0	4.8
500 - 599	2	4.3	1,099	12.1	27,459	10.2	48.3	7.3
1,000+	1	2.2	1,423	15.7	51,609	19.2	74.4	7.5
Total	46	100	9,049	100	268,525	100	53.6%	6.7

Source: Ministry of Health, Albania. Albania Health Indicators for Years 1993-2003. Note: (*) includes psychiatric hospitals with each having ALOS of more than 100 days.

Quality of health care is low.

11. **The quality of health care is low, particularly at the primary care level.** The substantial amount of primary care bypassing and qualitative surveys point to serious deficiencies in the quality of care, particularly at the primary care level. Quality of care standards and standard treatment protocols have not been developed and adopted for outpatient care, and providers do not have an established system for continuous quality improvement. The current incentive framework for providers gives no importance to quality of care. Quality issues identified by focus group participants and other surveys include low skills of medical staff, the lack of drugs, supplies and equipment, poor infrastructure, limited scope of services provided at PHC facilities, and the level of quality being conditional upon the informal amount a patient is willing to pay. Household survey data suggest that bypassing of primary care is more prevalent among the rural population and low-income groups, although seeking care at a higher end facility results in higher out-of-pocket payments and longer travel times. This suggests that the quality and scope of service delivery in primary care facilities in rural and peri-urban areas with a high concentration of poor households is of particularly concern.

12. **A recent survey on reproductive health found that the quality and coverage of prenatal care is of serious concern and ranks among the lowest in the ECA Region.** The survey found that while officially reported coverage of prenatal care is high, one in five women who gave birth between 1997 and 2002 did not have any prenatal care. This is one of the highest ratios in the ECA Region, and is similar to Central Asia. The survey also showed that 70 percent of pre-natal care provided was inadequate and that only one in five women had any postnatal follow-up. Although regional data on infant mortality are of questionable reliability, there are indications that mortality rates are higher in the poorest mountainous regions. Improvements in the quality of prenatal and obstetrical care will need to be given higher priority, particularly in the more disadvantaged regions, if Albania strives to move closer towards European averages for maternal and child health outcomes.

13. **Health personnel in Albania continue to remain isolated and lack in-service training to upgrade their skills.** At the same time, they are often over-specialized for the type of population-centered medicine needed to ensure that people can obtain comprehensive service at the primary care level. The limited efforts to strengthen clinical skills of primary care providers to date have been uncoordinated and dispersed. Albania's primary care physician and nurses have insufficient knowledge

about the prevention, detection, and management of non-communicable diseases and of other growing health risks such as HIV/AIDS. There is also a need to carefully review and determine the scope of services, which primary care providers can offer and ensure improved management of patient pathways.

14. **Quality improvement is a core objective of the Government's Health Sector Strategy.**¹ Albania has already undertaken substantial work on the establishment of quality standards for hospitals and strives to establish a hospital accreditation system. A set of quality standards covering the main domains of hospital functioning are currently being pilot tested. However, before a final decision on the appropriate mechanism to ensure quality control in the Albanian context is taken, it should be further assessed whether the financial and human resource capacities to support an accreditation system are available. Introduction of a quality improvement system will require a multi-pronged approach involving facilities managers, designated facilities staff, external surveyors, and the health insurance institute as the agency, which will purchase health services. It will also require raising awareness about the importance of continuous quality improvement among the medical profession as well as the wider population. Efforts at establishing and implementing standards will need to be complemented by skills upgrading of health care professionals.

As the provision of private health care is growing, the regulatory framework to ensure that the private sector will contribute to meet the country's overall health sector goals needs to be strengthened.

15. **Although the private sector is still relatively small, its importance in providing outpatient services is growing.** Dental care and the pharmaceutical sector are largely privatized. The provision of other health care is still dominated by public providers, but the importance of the private sector is growing in the areas of diagnostics and outpatient services. While public sector physicians and nurses are not allowed to operate in private practice (with the exception of university professors), anecdotal evidence suggests that the incidence of private care provided by publicly employed physicians may be growing. The 2004 household survey data found that somewhat over 10 percent of those who sought outpatient care did so from a private provider, although official statistics point to only 626 private outpatient doctor's offices and 907 licensed private physicians, compared to over 2,100 public outpatient facilities with over 10,000 medical staff. As the economy grows and the health system develops, private providers will invariably become more important players. The Government's Health Sector Strategy foresees that much of primary care would, in the medium to long term, be provided through independent primary care physicians or groups of independent physicians. Yet, an adequate regulatory framework and an effective system of safety and quality regulation and inspection have not yet been developed.

Albania has taken important steps towards enhancing the functioning of its pharmaceutical sector but further steps are necessary to contain costs, to improve the transparency in decision making and to strengthen quality assurance.

16. **Substantial steps have been taken to improve transparency along the pharmaceuticals distribution chain and to institute cost containment on HHI reimbursed prescription drugs and hospital drugs.** A new Drugs Law, enacted in 2005, simplifies the registration of new drugs but raises the bar in terms of quality standards, requiring approval in a major foreign market before a drug can be marketed in Albania. Local manufacturers have to adhere to European standards for Good Manufacturing Practice within 2 years. Irregularities in the distribution network are being addressed by a sticker system for legally marketed drugs. Competitive tendering for hospital drugs has resulted in substantial cost savings; and problems in the distribution to hospitals have been addressed through contracting with a private distributor, cutting back theft and diversion, and leading to significant savings. Price negotiations

¹ Government of Albania, Long Term Strategy for the Development of the Albanian Health System, July 2004. This document is referred to as the Health Sector Strategy in this note.

for innovative drugs reimbursed by HII, an internal reference pricing system for generic drugs and informal budgets for prescribing physicians have been introduced in an attempt to contain the rapidly increasing expenditures on prescription drugs. The large prescription drugs related HII deficit in 2005, however, suggests that these measures were not sufficient to curb rapidly increasing expenditures. Remaining challenges include introduction of additional cost containment measures for prescription drugs, strengthening quality control in the market, increasing transparency of various commissions that make decisions affecting the pharmaceutical market and further revising the margins on drugs to encourage consolidation of a fragmented wholesale and distribution system.

D. FINANCING HEALTH CARE

Low income groups are ill protected from health shocks and are easily thrown into poverty as a result of out-of-pocket spending on health care.

17. **The 6 percent of GDP which Albania spends on health care is in line with the average for lower middle income countries, but Albania's public sector contributes a below average share to these expenditures.** As a result of low public sector spending, out-of-pocket expenditures at the point of service account for almost 60 percent of sectoral funding. The high level of direct household spending indicates that the existing health financing system offers Albania's population limited protection against catastrophic illness or injury and allows for little redistribution of resources to protect the most vulnerable groups from health shocks. Although health insurance is mandatory, household survey data suggest that only between 40-45 percent of the population actually have a health insurance license and thus benefit from coverage. As is to be expected in a country with a large informal labor market, the coverage is significantly higher among the urban population and the upper income groups. Active contributors account for less than one third of the active labor force, pointing to large contribution evasion.

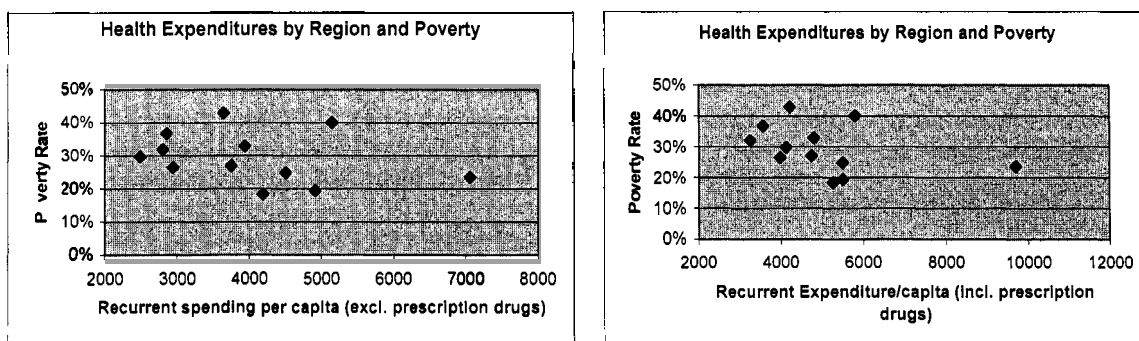
18. **The high share of out-of-pocket payments at the point of service and outside an overall health finance framework creates serious inequities in access, has a considerable poverty impact and limits effectiveness of the Government's sectoral stewardship.** Lower income households exhibit a significantly higher likelihood of incurring catastrophic health care expenditures than better off households. The average out-of-pocket spending for one episode of outpatient care amounts to 50 percent of the average monthly per capita expenditure of the lowest consumption quintile. Although the law provides for free inpatient care, survey data suggests that essentially everybody who is hospitalized incurs substantial costs and that informal payments account for at least one quarter of these costs. Average outlays for hospital care amount to four times the monthly per capita expenditure of the lowest consumption quintile. The likelihood of paying for health care and the absolute amounts paid are lowest in Tirana and highest in the mountainous regions. Such regional inequities are of particular concern in view of the high incidence of poverty in the mountainous regions. Household survey data suggests that income and insurance coverage are important determinants of seeking health care, despite the fact that insurance benefits are limited to primary care and drugs benefits only.

The health financing system is fragmented. It neither gives providers incentives for efficiency and quality improvements, nor does it establish clear lines of accountability.

19. **The continued fragmentation of the health finance system and at times unclear assignment of financing responsibilities have resulted in a lack of accountability for sectoral performance in general and individual providers' performance in particular.** The health finance system is fragmented with the MOH paying for hospital care, non-physician salaries, and at times other operating costs for primary care, while HII pays for salaries of primary care physicians, prescription drugs, and high-end diagnostics. Financing responsibilities have changed repeatedly over the past several years,

with local governments at times expected to cover operating costs for primary care. As a result of dispersed funding sources, the lines of accountability are unclear, particularly at the primary care level. The introduction of user fees for outpatient care for those not covered by health insurance or those who circumvent primary care has not been applied evenly and tended to create uncertainty among providers and patients, leaving ample room for abuse. While informal payments are relatively modest for outpatient care, they are widespread and substantial for inpatient care. Input based financing gives providers no incentive to improve quality or efficiency and has led to skewed geographic allocation of resources. The geographic imbalance in the provider network and human resource base, combined with uneven access to health insurance, have resulted in highly unequal distribution of public sector expenditure for health care, with regions with the highest poverty incidence generally receiving the least amount of public expenditure on health per capita as demonstrated in Figure 1 below.

Figure 1 - Recurrent Health Care Expenditures and Headcount Poverty Index by Region



E. IMPROVING THE HEALTH SECTOR'S ABILITY TO MEET THE POPULATION'S CHANGING HEALTH NEEDS

The main challenge for Albania's health sector is to consolidate the achievements in health outcomes to date, while establishing capacity to effectively address the growing incidence of non-communicable diseases and affording low-income groups better protection from impoverishing health expenditures.

20. Consolidating achievements in health outcomes, while also establishing capacity to effectively address new health needs and better protecting low-income groups from health risks, will require fundamental changes in the way health care is financed, delivered, and organized. These can best be summarized around three core pillars: (i) more efficient resource mobilization and allocation; (ii) improvements in quality of service delivery; and (iii) improvements in sectoral management and stewardship.

Resource Mobilization and Allocation

21. **Pool all public sector resources under one funding agency.** To improve efficiency in resource mobilization and allocation and ensure maximum accountability of the funding agency and providers, all public sector resources, meaning budgetary funds and health insurance funds, should be pooled and channeled through one agency (the Health Insurance Institute), which will then purchase health care on behalf of Albania's population from health care providers. Pre-conditions for successful expansion of a payroll tax based social insurance system are not met in Albania. Preconditions include a large formal

labor market, strong administrative capacity for contribution collection, good regulatory and oversight structures, and strong economic growth. If these conditions are not met, and they rarely are in middle-income countries, payroll tax based social insurance results in substantial inequity in access to health care; a problem, which Albania is already beginning to face.

22. **Rely on general taxation rather than payroll tax contributions as the main source of public funding for health care.** This note recommends that Albania consider phasing out the current 3.4 percent payroll tax contribution for health insurance and shift entirely to general taxation as a public source of funding health care, fiscal space permitting. Currently, only 7 percent of public sector spending on health come from non-budgetary contributions to HII, this amounts to only 0.2 percent of GDP and could be absorbed by the general budget over the next few years. A second best solution would be to maintain, but not increase, the current health insurance contribution rate, pool contributions with general revenues under the Health Insurance Institute (HII) and introduce a two-tiered benefits package. However, this solution would administratively prove substantially more demanding. In view of HII's limited administrative capacity, it would appear more prudent to focus on building up HII's capacity on the purchasing side and rely exclusively on a general revenue financed system in the years to come.

23. **Clearly define the health care benefits, which will be made available from public funds, and introduce copayments for a wider range of services, including inpatient care.** The amount of public sector funding for health care will invariably remain limited. To increase transparency, enhance provider accountability and improve equity in access; it is necessary to clearly spell out what services the population is entitled to receive free of charge from public providers, what services will require a copayment from the patient, and for what services the population must pay in full. The limited amount of public sector resources available in the medium term will require that copayments for most care be substantial and some high-end procedures be excluded from public funding. In view of the currently low consumption of primary care and its potential cost effectiveness, copayments for such care should remain relatively low, while substantially higher copayments could be introduced for higher order care, with hefty supplements for those who self-refer to higher order care. Protection mechanisms should be put in place to mitigate against the impact of the out-of-pocket payments for low-income groups. This could take the form of copayment limits for social assistance recipients or alternatively selected target groups using proxy means indicators. The high poverty impact of out-of-pocket drugs expenditures suggests that low-income groups should eventually be accorded limited drugs benefits. If funding is purely general revenue based, this would essentially mean that a single basic benefits package be introduced for all, with limits on copayments and limited drugs benefits for low-income groups and possible drugs benefits for other target groups. If the funding remains two-tiered (e.g., general revenues, plus payroll tax based contribution) general revenues would provide for a basic package for all, with expanded benefits for low-income groups commensurate to those received by HII contributors.

24. **Combine the introduction of increased copayments with broad based action to root out informal payments.** Informal payments create a substantial burden on those who seek care, both financially and through the uncertainty, which they create. Furthermore, these funds remain completely outside the managerial control of the health system. The objective of introducing broader copayments would be to formalize these payments, rather than to increase the already high out-of-pocket payments. Therefore, the introduction of wider formal copayments must be combined with aggressive efforts to curb informal payments, through public awareness raising campaigns, allowing providers to allocate a substantial amount of copayments collected towards performance based salary supplements, introduction of patient complaint mechanisms, and prosecution of gross violators. Evidence from other countries suggests that combining such efforts with the introduction of formal copayments does allow for reduction in informal payments. In the medium term, further revisions to the medical staff remuneration system will also be required, but these could be undertaken within the overall framework of changes to provider

payments. Given the prevalence of informal payments in hospitals, it is advisable that efforts first focus on reducing informal payments there.

25. Increase resource allocation for public health and health information. The health care system remains skewed towards clinical care, while public health initiatives remain underdeveloped and under funded. The increasing burden of noncommunicable diseases and the new health risk factors call for increased emphasis on health promotion and public health initiatives. Furthermore, the analysis of epidemiological trends in Albania is severely compromised by the availability and reliability of data. Incomplete and inadequate data cannot form the basis of effective policy. It poses the risk of distorted emphasis and attention. This is an area which has not received sufficient attention over the past. The Institute of Public Health (IPH) has a good basis and would be a natural body to assume responsibility for the collection and analysis of routine health information as well as increased focused research efforts. Similarly, IPH has a good basis and would be the natural locus for increased efforts in health promotion and public health initiatives. However, IPH can only effectively carry out these tasks if more resources are allocated towards health promotion, new public health initiatives, and health information and its capacity is further strengthened.

26. In the medium term, shift to a population based regional allocation of health sector funds. The current system of allocating funds merely based on existing infrastructure and human resources results in inequitable allocation of resources and gives health care providers no incentive to improve performance and efficiency. Therefore, as Albania introduces changes in the way providers will be financed and further streamlines the provider network, it may want to move toward a system where resources are allocated regionally on a risk adjusted capitation basis, with adjustment factors taking account of demographic and socio-economic factors.

27. In the medium term, improve the balance between public and private spending on health care to enhance the population's protection from health shocks. Albania spends about 6 percent of GDP on health care. While this is less than most ECA countries spend, it is about on par with the average for lower middle-income countries. However, Albania's share of public sector spending in total sectoral spending (38 percent) is below the average of lower middle-income countries (45 percent) and substantially below the average of upper middle-income countries (58 percent). Over time, Albania may wish to improve the balance between public and private funding, by gradually increasing the share of public funding. An increase in the share of public funding could be linked to the expansion of the publicly provided benefits package. The high share of private out-of-pocket funding creates serious inequities in access, has a considerable poverty impact and limits the effectiveness of the Government's sectoral stewardship. However, any increase in public funding should be closely linked to fundamental reforms in the way resources are allocated and utilized.

28. Finalize and use the hospital map as an instrument to guide any future investment in the hospital infrastructure. The large number of small hospitals with low utilization rates and poor physical conditions, overall low hospital occupancy rates and the continued indecisiveness about which hospitals should expand their capacity to serve as regional hospitals call for a careful evaluation of the country's hospital infrastructure. In view of the substantial remaining investment needs in the hospital sector, there is a critical need to finalize the hospital map based on efficiency, quality assurance, and accessibility considerations; and then utilize this map to guide further investments in the sector. While the poor quality of the road network may not allow for highest optimization of the hospital network in the medium term, there is, nevertheless, a need to consolidate those facilities, which are rarely utilized, but continue to consume a substantial amount of resources. Options to better organize the multiple departments with the same profile across a relatively small catchment area or at times even within the same hospital, should also be explored. The decision to establish a regional hospital that would provide a substantial range of

services in each of the 12 regional prefectures also deserves further consideration, in view of Albania's limited resources to maintaining such a network.

29. **Develop regional primary health care plans.** The overall low but largely varying productivity of primary care providers calls for an evaluation of current PHC planning standards and the revision of the scope of services, which GPs and PHC facilities can provide. Further investments in primary care facilities should be based on a thorough analysis of current and expected utilization of existing facilities and targeted efficiency improvements, rather than be driven by blindly applied coverage standards.

Improve Quality and Efficiency of Health Services Delivery

30. **Improvements in service delivery will require action on four fronts:** (i) upgrading the clinical effectiveness, (ii) changing the incentive framework for providers, and (iii) establishing a quality assurance system, and (iv) further consolidating reforms in the pharmaceutical sector.

31. **Consolidate pilot efforts to improve clinical effectiveness and quality of care.** Pilot efforts to develop clinical guidelines, to train primary care providers in their use and to introduce quality improvement and case management processes at provider level appear to have yielded promising results, as demonstrated by lower bypass rates and an increase in visits to concerned primary care facilities. These efforts should now be taken a step further by institutionalizing the development and adoption of treatment and prescribing guidelines, establishing a national in-service training program for physicians and nurses, and developing and implementing a training program. The latter could initially focus on providing primary care staff with the skills necessary to better meet the population's demand for health care. While there clearly also is a need to improve the skills of outpatient specialist and hospital physicians, the substantial amount of primary care bypassing and the need to strengthen capacity for health promotion, and primary and secondary prevention for noncommunicable diseases, make skills improvement at the primary care level a first priority. However, efforts to strengthen the clinical skills of providers are unlikely to reap the desired results unless they are accompanied by changes in the incentive system.

32. **Shift from input based financing of health care providers to performance based payments.** Under the current input based financing system, providers have no incentives to increase efficiency and improve quality and quantity of care. It is therefore suggested that the payments for providers be changed to a performance based system by means of having HII contract with providers for a defined bundle of services. Experience in other transition economies as well as OECD countries suggests that capitation based payments (with possible performance supplements) for primary care and global budgets with case mix adjusters may present a good basis for such changes in Albania. It would, however, be critical that capitation payments (or a variant thereof) for primary care include the full cost of providing care (including operating costs and allowance for equipment depreciation) and be based on actual enrollment of patients with a particular doctor or facility. The development of global budgets for hospital providers would need to occur gradually. The introduction of case mix adjusters would be conditional upon provider information systems becoming more developed so that they can provide the necessary data on the financial and clinical performance of facilities and, ultimately, of facility departments. Work in this respect could build on the achievements to date at Durres Hospital. However, such changes can only be expected to lead to desired behavioral changes of providers if they are accompanied by organizational changes, which give providers increased managerial autonomy and by efforts to strengthen the quality of care.

33. **Establish a quality assurance system.** Ongoing efforts to establish hospital quality standards should continue, in parallel with the development of quality standards for primary care. Standards should cover clinical care, administrative and financial services, as well as facilities and equipment. The

feasibility of establishing an accreditation system deserves further review on fiscal sustainability grounds. As a first priority, the provider licensing system would benefit from substantial strengthening so that it can serve as an instrument to ensure higher quality of care. This would require the development of new licensing standards and the development of capacity in the MOH to enforce these standards. Physician licenses could be rendered more meaningful if they were subject to periodic renewal (re-licensing), conditional upon completion of continuing education requirements.

34. **Consolidate reforms in the pharmaceutical sector.** The possible expansion of drugs benefits to a wider population group, together with stricter registration requirements for generic drugs, are likely to put additional pressure on already rapidly increasing drug expenditures. Further steps are therefore necessary to curb the rapidly increasing expenditures on prescription drugs. This will require keeping a close watch on prescription patterns, reviewing the copayments structure and copayment exemption policy, tightening the positive list of reimbursable drugs, and introducing an indication reference group based reimbursement system for innovative drugs. A review of the positive drugs list and copayment policies could take place within the framework of the overall definition of the publicly financed benefits package. The structure and level of margins for distributors and pharmacists also deserve further review. Current margins are relatively high and do not encourage consolidation of the fragmented distribution system. The composition and modus operandi of the main commissions dealing with registration, reimbursement of drugs, and licensing of professionals would benefit from further review to rule out conflict of interest and to increase the transparency of their decision making. The capacity for quality assurance needs to be strengthened to avert widespread perception of the low quality of many generic drugs. In the absence of local laboratory capacity, this service could be contracted from a qualified international laboratory, but a rigorous system of random sampling at customs and in retail pharmacies, combined with public information about potential quality violations and decisive action against violators, will need to be established.

Improve Sectoral Management and Stewardship

35. **The roles and responsibilities of all core actors in the sector need to be clearly defined and accountability mechanisms established.** Accountability in Albania's health sector is weak due to unclear definition of responsibilities, lack of proper performance standards and monitoring tools and insufficient integration of feedback from stakeholders into policy formulation and decision making. The Government's Health Sector Strategy and the reforms proposed here entail substantial changes in the roles and responsibilities of various actors in the sector. The MOH would assume a policy making and stewardship role and increasingly withdraw from service provision and financing of health care. The HII would assume full responsibility for financing of health care, channeling the Government's health budget to health care providers by contracting them to offer a defined set of services to the population against an established price. Service providers would be given increased autonomy to decide how to most effectively produce these services and their performance would be evaluated against an established set of performance standards. These changes require a supportive legislative framework, establishment of performance standards and monitoring tools, and most of all, a clear definition of each actor's functions and responsibilities. They would also require substantial stakeholder consultation to ensure broad based support for the proposed changes and adequate capacity building at MOH, HII and provider level.

36. **The potential role of regional health authorities needs to be reviewed in light of the pilot experience gained in Tirana and a decision needs to be made about the future of regional health authorities in Albania.** The Tirana Regional Health Authority (TRHA) was established in the Tirana region as a pilot experiment, with the objective to consolidate previously dispersed public health, health planning, and health management functions under one umbrella, and optimize service delivery in the Tirana region. The experiment did not reach its expected results for a variety of reasons. The effectiveness of RHAs stems mainly from their ability to allocate the available funding amongst service

providers in a region and make the necessary trade-offs to improve the overall quality and access to patient care. This, however, requires that RHAs be granted full autonomy to make such decisions and calls for highly skilled managerial talent to prepare for, propose, and subsequently execute such decisions. The experience in Tirana suggests that the required skills may be difficult to find in Albania, and that there is a continuous danger that MOH retains decision rights, thus obviating potential benefits of RHAs. If these conditions are not met, it is unlikely that the benefits of the RHA approach outweigh the costs in terms of an additional layer of management and decision-making, and especially in terms of the use of scarce managerial talent. This would suggest that the direct purchasing model, whereby HII would contract individual providers or groups of providers directly, may be a more appropriate solution to consider for Albania, and that the further expansion of RHAs should be carefully revisited. Therefore, it is recommended that the Government commission an external evaluation of the TRHA pilot as a basis for a decision about the role of RHAs in Albania in general and TRHA in particular. The TRHA was conceived as a pilot and therefore calls for careful evaluation and corrective action based on the evaluation results.

37. **Organization and management of primary care providers.** The Government's Health Sector Strategy envisages that primary care will eventually be provided through independently contracted general practitioners or groups of such practitioners. While this is the model, which many ECA countries have adopted, it would be important to carefully evaluate the feasibility of such arrangements for primary care provided in rural areas. Alternative set-ups to consider for rural areas might be community based health organizations or affiliation of rural health care providers with urban providers under an umbrella contract with HII. To this effect, stakeholder consultations with providers in rural areas might be carried out and the feasibility of various organizational arrangements in the Albanian context further evaluated.

38. **Increasing autonomy for hospitals.** The Government's Health Sector Strategy and proposed amendments to the Hospital Law foresee that hospital providers will become autonomous non-budgetary not-for-profit public organizations governed by a board, while the MOH will retain the right to appoint the hospital director. This points to inherent conflict between granting providers increased autonomy under the governance of their boards and the MOH's reluctance to withdraw from service delivery. It also points to a need to further evaluate the proposed governance structures for autonomous hospitals. Increasing autonomy of hospitals will require substantial capacity building, both of hospital managers and of the governing board members, and important decisions will need to be taken about the extent of autonomy, which such institutions will be granted. In the medium term, granting hospitals full autonomy, including over decisions of the desired profile, scope of services to be provided, and large investments is not advisable in the Albanian context. Similarly, it is not advisable in the medium term to grant hospitals full financial autonomy to the extent of letting them borrow commercially for investments. On the other hand, as provider management capacity increases, providers could be granted increased autonomy over human and financial resource allocation within a given budget, including staffing positions and salaries, and they could be given the right to decide on the utilization of potential savings achieved under HII contracts.

39. **Population feedback and community participation.** To date, both community participation in the health sector and seeking direct feedback from the population on sectoral performance have been largely neglected. Local authorities and community representatives can play an important role in ensuring accountability of providers through, for example, representation on provider governing boards and through participation in local or national sectoral performance reviews. To the extent that the reforms will be implemented gradually on a regional basis, the Government may wish to institute regular stakeholder consultations and sectoral performance discussions with the involvement of sectoral and community representatives. Sectoral performance targets for the region could be established, monitoring mechanisms agreed upon, and outcomes subsequently reviewed on a regular basis. Targets could include provider performance indicators, health outcomes, and the extent of financial protection of low-income

groups. Similarly, feedback mechanisms from users of health services, particularly as the reforms begin to take hold, will be of critical importance to gauge the success of such reforms. In the short and medium run, this would require specific efforts to gain such feedback through patient satisfaction surveys, possible report card systems as they have been introduced by Tirana Municipality, focus group discussions, provider utilization surveys and the establishments of patient complaint mechanisms. In the longer run, more organized feedback through patient right organizations or similar set-ups might take hold.

Implementation

40. **The changes in the organization and financing of health care will require a gradual introduction and careful preparation and capacity building of health care providers, HII, and MOH** to ensure that they are ready to assume their increased responsibilities. Fundamental decisions on the legal status, organizational arrangements, governance structures, and extent of autonomy for health care providers will need to be taken before such changes can be introduced. Provider accounting systems need to be strengthened, performance standards established, and adequate provider reporting and information systems introduced to allow for appropriate performance monitoring and transparency. Provider management capacity will need to be developed and payment reforms will need to be coordinated with efforts to improve the quality of care to enhance payment mechanisms' incentives for behavioral change on the provider as well as the patients' side. Therefore, it is proposed that the Government consider implementing reforms in a phased approach. The first phase would be a preparatory phase, which would involve deciding on provider organization and governance structures, developing appropriate accountability and reporting mechanisms, developing and costing out the benefits package to be made available from public funding, enhancing the legislative framework to support the changes, and establish training programs in provider management and clinical skills upgrading. The second phase would gradually introduce changes in provider organization and financing in parallel with upgrading of clinical and managerial skills. Building on work already undertaken with the support of USAID financing, the emphasis during the second phase would be on supporting the gradual roll out of changes at the primary care level, while piloting proposed managerial and financing changes in a limited number of hospitals only. During a third phase, reforms would be further expanded across the remainder of the hospital network. In parallel, during the first and second phase, the capacity of the IPH to assume increased responsibilities in health promotion, health information and health intelligence, and new public health initiatives, would strengthened.

CHAPTER 1: HEALTH STATUS OF THE ALBANIAN POPULATION

A. INTRODUCTION

1. Over the past decade and a half, Albania has undergone major political, economic, and social changes that have affected almost all aspects of the population's life, including health outcomes and health care services. Despite some progress over the past decade, the population's health status remains below that of most other countries in the region. Moreover, the transition years have resulted in marked lifestyle changes and exposure of the population to new health risks.

2. After a brief discussion of data sources and limitations, this chapter will first review the demographic changes that have occurred over the past 15 years and present the current demographic situation. It will then review the health status of the population, examining the core health indicators and the causes of mortality and morbidity. The next section will look at the determinants of health status. The chapter ends with a section that spells out the main health challenges that the Albanian health system must be prepared to face over the coming years.

B. SOURCES OF INFORMATION AND DATA QUALITY CONCERNS

3. **An analysis of the Albanian population's health status and the main health challenges is rendered difficult by data limitations.** The available data on the population's health status are scarce and often of questionable reliability. There is a need to establish a reliable health information database, which could help guide sectoral policy and investment decisions. This chapter draws on a variety of data sources in an attempt to provide a picture of the population's health status and its main determinants.² Often, the picture presented by these data is inconsistent and difficult to interpret. While the available information is deemed sufficient to identify the main health status trends and key health challenges, the available information must be used and interpreted with caution. The chapter will draw comparisons to other countries in the region where the data permit. Data on many key health status aspects are missing. For example, essentially no information is available on the incidence of noncommunicable diseases and their main risk factors. No information is available on the health status of core vulnerable groups and no data exist to draw credible conclusions about regional variations in health outcomes or health outcome differences across socioeconomic groups.³ Box 1.1 illustrates some of the key data issues faced.

² Data utilized in this chapter include administrative data from MOH, INSTAT and IPH, data from international data bases, including the WHO' Health For All (HFA) database and the World Bank's World Development Indicators. Data from the Albania Reproductive Health Survey (2002), the Living Standards Measurement Survey (2002) and UNICEF's Multiple Indicators Survey (2000) are also utilized.

³ Household survey data provide some indication of health status across broad geographic areas and income groups; however, they are based on self-reported health status and are not specifically designed to provide reliable health status information, as, for example, a Demographic and Health Survey would be.

Box 1.1 - Demographic and Health Status Data Concerns – An Illustration

Demographic and health indicators for Albania are affected by a variety of issues, which call for caution when interpreting the data. The following illustrates some of the issues affecting the data.

1. Most of the indicators for the period 1989-2001 have been calculated using denominators based on projections from the 1989 Census. The large migration waves during this period are likely to have affected these denominators and thus cast some doubt on the reliability of data from this period.
2. In some locations, the registration of vital events was significantly and durably disrupted by the events that followed the collapse of the pyramid schemes in 1997. This has further affected the quality of routine registration data, which, in any event, remain incomplete.
3. In Albania, the number of officially registered births varies significantly from one year to another: for example, from 52,888 in 2001 to 42,273 in 2002 (a 20 percent difference). While such large variations have been observed in some countries in the past and attributed to clearly identified factors, the underlying factors for such a drastic change in Albania are not clear.
4. Infant under-five and maternal mortality are difficult to estimate in most countries owing to incomplete reporting and the sensitivity of the enumerator to even small absolute changes in events. This is particularly true for countries with small populations and a small number of vital events. Thus, an increase of two maternal deaths per year in Albania can lead to a 25 percent increase in maternal mortality statistics.
5. Different methods of analysis used to produce estimates of demographic measures can result in different figures, which, in some cases, contradict each other. This is, for example, the case with Albanian life expectancy figures. According to official Albanian figures, life expectancy at birth was 75.7 years in 2003, while the WHO's HFA database shows an estimated life expectancy at birth of 70.4 years. Based on official figures, Albania enjoys the longest life expectancy in the Balkans, above the average for the entire European region and just 2 years below the average for EU countries. WHO estimates show a completely different picture, with life expectancy in Albania being the lowest in the Balkans, 3 years below the average for the entire European region and 8 years below the average for EU countries.
6. The results of household surveys can also provide a very different picture from that of the official data and, in some cases, are hardly reliable despite the robustness of the methodology used. For example, the Multi Indicator Cluster Survey conducted in 2000, surveyed the immunization status of children based on data from vaccination cards and mothers' declarations. It found that only 17 percent of children had all eight recommended vaccinations by their first year, with a measles immunization rate of only 61 percent. Official figures for the same year show measles vaccination coverage of 92 percent. No outbreaks of any of the related diseases were reported. The 2002 Albania Reproductive Health Survey reported a number for induced abortions that was 64 percent lower than the official data, leading to the conclusion that the underreporting of abortions would make survey results unreliable.

C. DEMOGRAPHIC PROFILE

4. **Albania's demographic profile is characterized by three main phenomena: large internal and external migratory waves, improving mortality rates, and declining fertility rates.** The 2001 Census put Albania's population at 3,063 million. Based on projections from this Census, the population was estimated at 3.1 million in 2004 and is expected to increase to about 3.7 million by 2025.⁴ While Albania remains one of the youngest countries in Europe, the population's age structure has changed significantly in the past decade. The population below 15 years of age is now decreasing and the population over 65 years is growing faster than the rest of the adult population. The Albanian population is still predominantly rural, although the cities, particularly Tirana, have grown very rapidly over the past 15 years.

C.1. Internal and External Migrations

5. **Migration has been a dominating socioeconomic fact over the past 15 years. Migratory flows have been both international and internal, and permanent and temporary.** With the return of political stability and economic growth, migratory flows have begun to stabilize somewhat. Following the collapse of the Hoxha regime, a great migratory wave began.⁵ During the 1990s, about 20 percent of the population left the country and are now living abroad. A second peak of international migration followed the collapse of the pyramid schemes in 1997. Most of the foreign residents live in Greece, Italy, and other countries of the European Union.

6. Large internal migration movements have taken place from rural to urban areas as well as from smaller to bigger cities. The main flows of internal migrants originated from the Northern Mountain and the Center regions towards Tirana and Durres. As a result, about 60 percent of households currently have at least some members who were not born in the municipality in which they currently reside. In addition to permanent migration, temporary migration has also been common among Albanians since the 1990s. The 2002 LSMS reported that about 10 percent of households had at least one adult who had been absent for one month or more in the year prior to the survey. The vast majority of temporary migrants travel to Greece. International migration has been an important part of many households' strategy to cope with economic transition. Remittances have been the largest source of foreign exchange.

7. **International and internal migration have several important implications for the health sector.** First, the health sector workforce lost a significant amount of staff to international migration. While almost 2,200 physicians have graduated since 1992, the ratio of doctors to the population has essentially remained unchanged. Albania lost over 2,800 nurses to migration over the past decade. Second, remittances constitute an important source to finance out-of-pocket health care expenditures. The 2002 LSMS showed that about 9 percent of remittances are used to cover medical expenses. Third, large internal migration from rural to urban areas has resulted in further misalignment of the health care provider network with population needs, while it has also left some of the more remote areas without adequate medical staff. Fourth, while migration to urban areas has resulted in improved living conditions and access to health care for some, others have ended up in peri-urban areas, which remain inappropriately served with basic amenities and health care services. Finally, the economic transformation and internal migration have precipitated lifestyle changes and exposure to new health risks, as reflected by the sharp increase in smoking and car accidents.

⁴ Population Reference Bureau, 2003.

⁵ For more detailed information on internal and external migration, see the World Bank Albania Poverty Assessment, Report No. 26213-AL, 2003, Chapter VIII, pages 121-134.

C.2. Geographic Distribution of the Population

8. **With 58 percent of its population living in rural areas, Albania has one of the highest rural population shares in Europe and the highest in the Balkans.** Based on the 2001 population and housing census, about 58 percent of the population live in rural areas. However, the urban population has grown rapidly, from about 36 percent in 1989 to 42 percent in 2001. The 2001 population distribution by region and prefecture is presented in Table 1.1. The Tirana region now accounts for about one-fifth of the total population.

Table 1.1 - Regional Distribution of Population, 2001

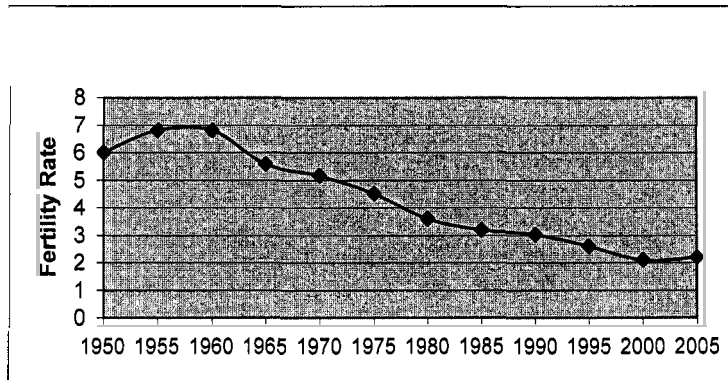
Region	Population	% of total
Berat	193,020	6.3
Elbasan	362,736	11.8
Gjirokaster	112,831	3.7
Korce	265,182	8.6
Shkoder	256,473	8.4
Durres	245,179	8.0
Fier	382,544	12.5
Lezhe	159,182	5.2
Vlore	192,982	6.3
Diber	189,854	6.2
Kukes	111,393	3.6
Tirana Region	597,899	19.5
Total	3,069,275	100

Source: INSTAT.

C.3. Population Growth

9. **Population growth and fertility rates have been falling, but Albania still has one of the highest fertility rates in Europe.** The population growth rate has been declining steadily, from above 3 percent in the 1960s, to slightly over 2 percent between 1970 and 1990, and to about 0.5 percent since then. Owing to migration, the overall population dropped by over 200,000 between 1990 and 2001. Based on the 2001 Census, the annual natural increase in the population is estimated at about 20,000 persons. Official figures point to a marked decrease in the fertility rate over the past five decades, from about six in the 1950s to three in 1990 and 2.1 in 2001 (Figure 1.1). This would put the current fertility rate at about the replacement rate. Other sources point to a somewhat higher fertility rate. The 2002 Reproductive Health Survey (RHS) estimates the total fertility rate at 2.6 percent, which is only slightly higher than the rates estimated by the WHO (2.4 percent) and the UN Population Division (2.3 percent). The crude birth rate is officially estimated at around 15 live births per 1,000 in 2003, a decrease from about 23 percent in the early 1990s. Albania has the highest fertility rate in the South East European region (Table 1.2) and one of the highest in the European region, but it is below that of Turkey and Central Asia.

Figure 1.1 - Albania Fertility Rate, 1950-2005



Source: Falkingham and Gjonca, 2001, INSTAT.

Table 1.2 - Fertility Rate in Albania and Neighboring Countries, 1990-2003

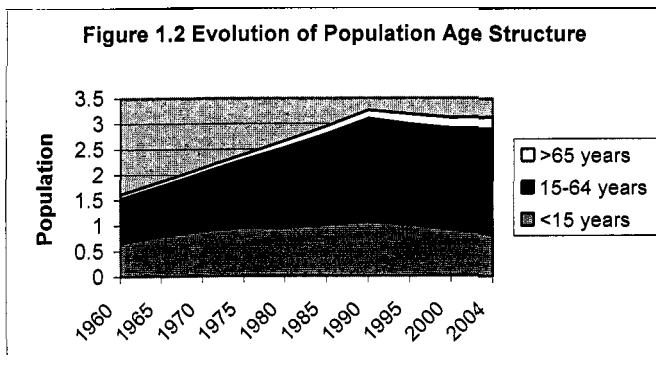
	1990	1995	2000	2003*
Albania	3.0	2.6	2.4	2.0
Bosnia and Herzegovina	1.7			1.4
Croatia	1.6	1.6	1.4	
Greece		1.3	1.3	1.3
Italy		1.2	1.2	1.2
Romania		1.3	1.3	1.3
Serbia and Montenegro	2.1	1.8	1.7	1.6
Slovenia	1.5	1.3	1.2	1.2
TFYR Macedonia	2.1	2.0	1.8	

* 2003 or latest available year.

Source: UNICEF Social monitor 2003 and WHO HFA database.

C.4. Population Age Structure

10. Albania is still characterized by a relatively young population, but the number of people over 65 years of age is expected to double in the next 20 years. The population age structure has changed significantly over the past few decades (Figure 1.2). INSTAT data show that somewhat over one-quarter of the population is aged 0-14 years and 46 percent of the total population is less than 25 years old (Table 1.3). Less than 8 percent of the total population is above 65 years and less than 3 percent of the population is above 75, a much lower proportion than that observed in neighboring countries. The population over 65 years is however growing relatively rapidly--by 3 percent, or about



Source: World Development Indicators.

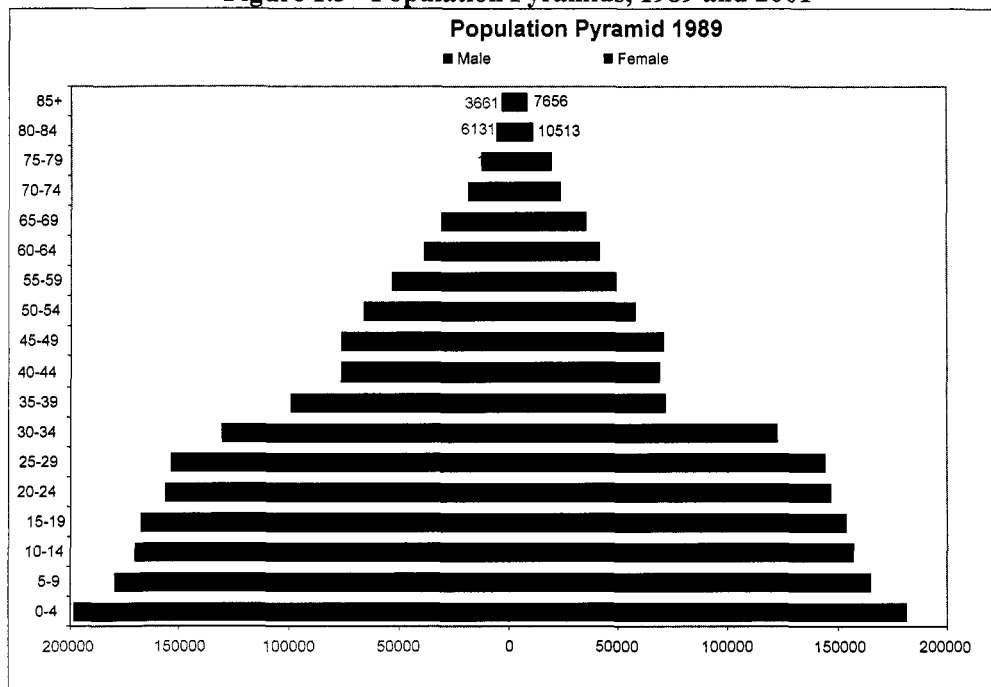
9,000 individuals per year. The elderly population is growing at a significantly higher rate than the population between the ages of 15 and 64 years (1.3 percent) and is expected to double in the next 20 years. Overall, the population pyramid has been affected by migration and declining fertility. While the top of the pyramid does not yet show a major expansion, the youth base has started to shrink (Figure 1.3).

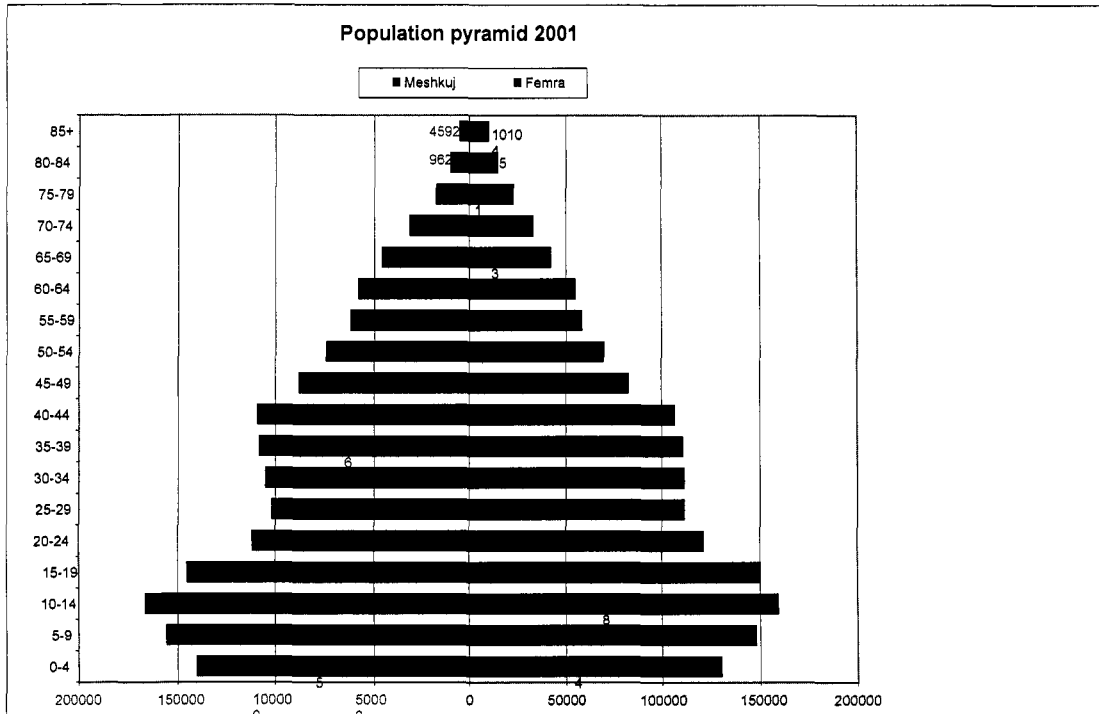
Table 1.3 - Age Structure of the Albanian Population

	1990	2001	2004
Age groups			
0-4	11.7%	8.9%	8.2%
5-9	10.7%	10.0%	9.1%
10-14	10.1%	10.6%	10.0%
15-19	9.8%	9.6%	10.1%
20-24	9.5%	7.5%	8.3%
25-29	9.3%	7.0%	7.0%
30-34	8.2%	7.0%	6.7%
35-39	6.3%	7.3%	6.8%
40-44	4.8%	7.0%	7.1%
45-49	4.5%	5.5%	6.2%
50-54	4.0%	4.6%	4.9%
55-59	3.3%	4.0%	3.8%
60-64	2.6%	3.7%	3.9%
65-69	2.1%	2.8%	3.1%
70-74	1.4%	2.1%	2.2%
75-79	1.0%	1.3%	1.4%
80+	0.8%	1.3%	1.3%

Source: INSTAT.

Figure 1.3 - Population Pyramids, 1989 and 2001





Source: INSTAT

D. POPULATION HEALTH STATUS

D.1. Life Expectancy

11. **Albania's life expectancy compares relatively favorably to that of other lower middle-income countries.** Official Albanian statistics show a life expectancy at birth of 75.7 years in 2003 (Table 1.4), with a female life expectancy of 76.4 years and a male life expectancy of 71.7 years. These data would suggest that Albanians enjoy the longest life expectancy in the Balkans following Slovenia, above the average for the entire European region and just 2 years below the average for EU countries (Figure 1.4). WHO data, however, paint a different picture, with an estimated life expectancy at birth of 70.4 years -- 67.3 years for men and 74.1 years for women. Based on WHO estimates, life expectancy in Albania is the lowest in the Balkans, 3 years below the average for the entire European region and 8 years below the average for EU countries.⁶ Compared to other lower middle-income countries, however, Albania's life expectancy compares relatively favorably, using either data source. This "Albanian paradox"⁷ is often attributed to the Mediterranean lifestyles and, more specifically, to a diet characterized by high consumption of fruits and vegetables, and low consumption of meat and milk products. Although diet seems the most plausible explanation, other factors may also have contributed to lower mortality in Albania, including the high physical activity and relatively low prevalence of smoking before the transition. Data inconsistencies make it difficult to assess the impact of the social and economic

⁶ WHO uses special demography techniques to estimate vital statistics for countries where birth and death registrations are known to be incomplete. WHO estimates can result in vital statistics, which differ substantially from those based on officially registered birth and death figures. Albania falls into this category. For details, see WHO, Health For All database, 2005.

⁷ Arjan Gjonca, Martin Bobak: "Albanian Paradox; Another Example of Protective Effect of Mediterranean Lifestyle?"- *The Lancet*, Vol. 350, 1997.

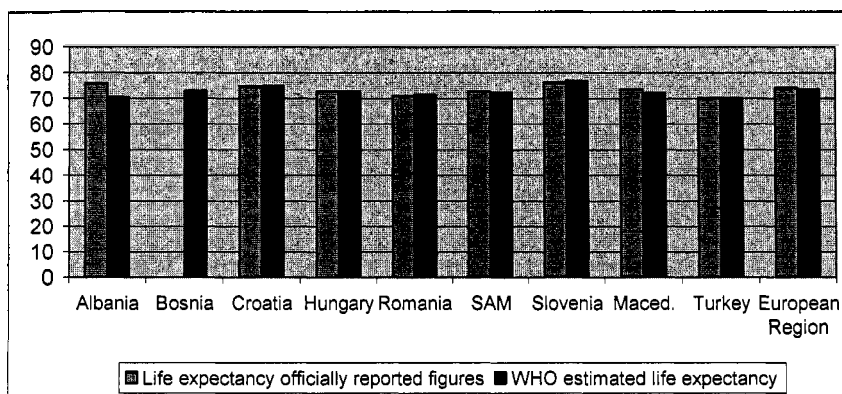
transition on life expectancy. Official statistics indicate that life expectancy dropped by about one year between 1990 and 1995, but has since increased by 3 years.

Table 1.4 - Life Expectancy at Birth According to Various Sources

	1980	1985	1990	1995	2000	2003
Total Population						
Albania official statistics	69.5	71.9	72.2	71.4	74.0	75.7
World Development Indicators			72.2	71.3		74.0
WHO estimated life expectancy					68.9	70.4
Male Population						
Albania official statistics	67.0	68.7	69.3	68.5	71.7	73.3
World Development Indicators			69.3	68.5		71.7
WHO estimated life expectancy					65.1	67.3
Female Population						
Albania official statistics	72.3	75.5	75.4	74.3	76.4	78.4
World Development Indicators			75.4	74.3		76.4
WHO estimated life expectancy					72.7	74.1

Source: INSTAT, WDI, WHO-HFA database, 2005.

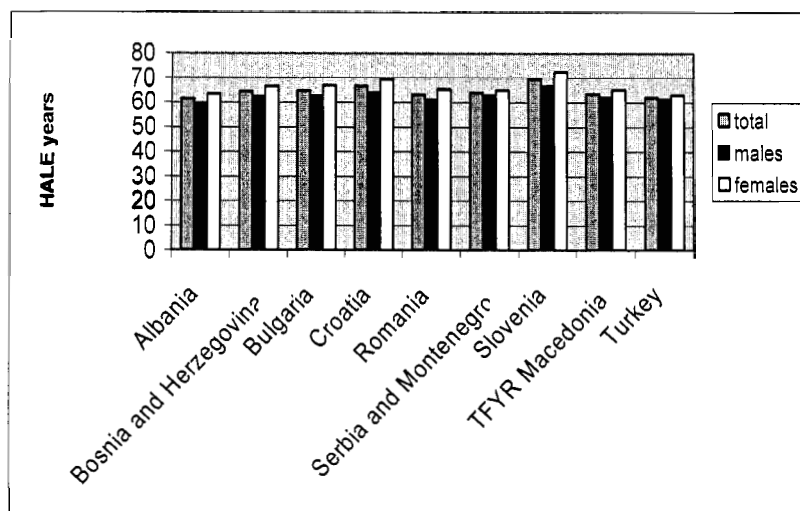
Figure 1.4 - Life Expectancy: Albania and Other SEE Countries



Source: WHO – HFA, 2005.

12. **Albania fares worst in the South East European region in terms of healthy life expectancy.** WHO's healthy life expectancy indicator measures the equivalent number of years in full health that a newborn child can expect to live based on the current mortality rates and the prevalence distribution of health status in the population. In 2002, WHO estimated healthy life expectancy at birth in Albania at 61.4 years, with 59.5 years for males and 63.3 years for females (Figure 1.5). This places Albania below other countries in the South East European region. The gender gap (3.8 years) is just below the average for the region (4 years).

Figure 1.5 - Healthy Life Expectancy: Albania and SEE Countries



Source: WHO-HFA, 2005.

D.2. Mortality Rates and Causes of Death

D.2.1. Infant and Under-five Mortality Rates

13. **Although all data sources point to an encouraging improvement in infant mortality over the past decades, Albania's infant mortality rates continue to compare unfavorably with those of other countries in the region.** Official MOH figures, based on civil registration reports, show an infant mortality rate of 16 per 1,000 live births in 2000 and 15.5 in 2003 (Table 1.5), down from 28.3 in 1990 and from 35.4 in 1993. The World Development Indicators data and WHO data also point to a considerable decrease in infant mortality over the past decade, but show slightly higher absolute levels, although also drawing on official statistics. Other sources, however, use much higher figures of infant mortality. For instance, the Multiple Indicator Cluster Survey, conducted in 2000 by UNICEF, estimated infant mortality at 28 per 1,000 live births using a simulation model that corrects for underreporting based on survey and other data, 75 percent higher than the official rate. Using a similar model, WHO estimates for 2000 show an infant mortality rate of 23 per 1,000 live births in 2000, almost 50 percent higher than the government's reported estimates. Similarly, the 2002 Reproductive Health Survey calculated an infant mortality rate of 26.2 per 1,000 for the period 1997-2002. Given the known reporting difficulties, particularly in the more remote areas, it is likely that the official figures present a considerable underestimate. Based on WHO estimates, Albania has the highest infant mortality rate in the South East European region (Figure 1.6) and one of the highest in the European region. However, irrespective of the source, infant and child mortality rates compare favorably to the average for lower middle-income countries and put Albania at a similar level as, for example, Colombia and Thailand. Figures for under-five mortality vary from 18 to 33 per 1,000 live births, depending on the source.

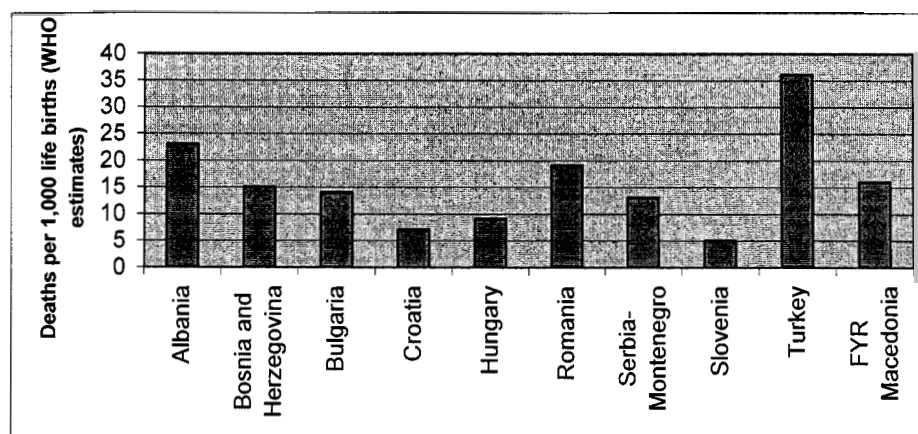
Table 1.5 - Infant and Child Mortality Rates According to Different Data Sources

	1970	1975	1980	1985	1990	1995	2000	2003
Infant Mortality Rate								
MOH/IPH					28.3	30.0	16.0	15.5
UNICEF 2000 MIC Survey							28.0	
World Development Indicators	78.0		55.0		37.0	25.0	22.0	18.0
WHO estimates							23.0	
Under five mortality rate								
MOH/IPH					41.5	37.0	20.4	22.1*
UNICEF 2000 MIC survey							33.0	
World Development Indicators	10.09		72.0		45.0	34.0	25.0	21.0

* Figure for 2002

Source: Ministry of Health, UNICEF, WDI, WHO-HFA.

Figure 1.6 - Infant Mortality Rate in Albania and Neighboring Countries



Note: Figures are WHO estimates for 2002 or latest available.

Source: WHO-HFA, 2005.

14. **About 40 percent of infant deaths occur during the first month of life and one-quarter occur during the first week, suggesting that improved prenatal care and post-natal follow up during the early weeks of life should be given a higher priority.** Analysis of infant mortality data between 1995 and 2000, carried out by the Institute of Public Health (IPH), showed that early neonatal deaths (0-6 days) accounted for about one-quarter of all infant deaths, deaths during the first month of life accounted for about 40 percent, and 60 percent occurred between the second month and one year of age.⁸ The 2002 Reproductive Health Survey found similar results. This suggests that improvements in prenatal care to screen for high-risk pregnancies, combined with improved obstetrical care and higher quality follow-up during the first weeks after birth, should constitute a relatively high priority for the health care system.

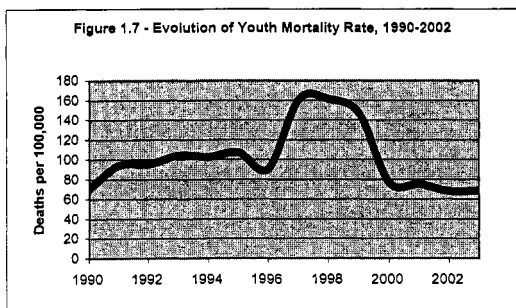
⁸ Institute of Public Health, "Epidemiological Studies of Infant Mortality in Albania: A Descriptive Study," 2003, and "Epidemiological Studies of Infant Mortality in Albania: A Case Control Study," 2004.

Not surprisingly, the IPH study found that the mother's level of education was an important predictor of infant mortality, as were the quality of the dwelling, the presence of a smoking father, the number of prenatal visits, and cesarean sections. The child's gender and birth order were not found to be significant determinants of infant mortality.

15. Statistical series on infant mortality by district, produced by the MOH, show considerable variations over the years in the number of registered births and deaths. In some cases, these variations are due to a statistical bias (small number of events), but in many others, they are probably due to unreliable reporting, including underreporting. Therefore, the available regional and district data are judged not sufficiently reliable to permit credible conclusions to be drawn on regional variations in infant mortality.

D.2.2. Youth Mortality

16. **Albania's youth mortality rate peaked in 1997 owing to violence, but it has recovered since then.** As elsewhere, young people (15-24 year olds) have the lowest mortality rate among any age group in Albania. During the transition, the death rate among young people increased significantly, from 74 per 100,000 population in 1989 to a peak of 148 per 100,000 in 1997. The rate has now returned to the pre-transition levels, at around 66 per 100,000 (Figure 1.7). Data from the mid-1990s (prior to the 1997 events) show that the death rate among young people in Albania was significantly higher than that in other transition economies, and was principally driven by violence and motor vehicle accidents.⁹



Source: INSTAT.

D.2.3. Maternal Mortality

17. **Although progress has been made, maternal mortality rates in Albania still appear relatively high in comparison with other Balkan countries.** The officially reported maternal mortality rate (MMR) was 18 per 100,000 live births in 2003, pointing to a decrease of 30 percent over the past 20 years. However, other sources, such as UNICEF and the World Bank's World Development Indicators, estimate a significantly higher maternal mortality rate (55 per 100,000 live births in 2000). Worldwide, the measurement and analysis of maternal mortality is problematic because of complex data collection and computation methods, and therefore such differences in maternal mortality rates are not surprising.¹⁰ With the relatively small absolute numbers involved in Albania (eight reported deaths in 2003), even a minimal change in the enumerator can result in substantial variations. Given the state of obstetrical services in Albania, it is likely that the maternal mortality rate is above that officially reported. Even with officially reported data, however, Albania compares relatively unfavorably with many other countries in the region (Table 1.6).

⁹ INSTAT, "Youth and Transition: Issues Confronting Albania's Key Resource," 2003.

¹⁰ WHO estimates maternal mortality using: (i) routine mortality data by cause statistics as reported to WHO by the Central Statistical Offices, and (ii) Hospital data reported to the Ministries of Health. Experts argue that even in countries with good vital registration systems, maternal mortality is actually higher by approximately 50 percent. WHO, UNICEF and the UNFPA have developed adjusted estimates to take into consideration the underreporting of events.

Table 1.6 - Officially Reported Maternal Mortality Rates, Albania and Neighboring Countries

	1996	2003*
Albania	32.1	18.0
Bulgaria	19.3	5.7
Croatia	1.8	7.5
Greece	4.9	3.9
Hungary	11.4	7.4
Italy	3.7	2.0
Macedonia, FYR		3.7
Romania	41.0	30.5
Serbia and Montenegro	7.2	5.7
Slovenia	26.7	17.2
European region	20.6	15.6

* Or latest available.

Source: WHO HFA, 2005.

D.2.4. Main Causes of Death

18. **There has been a significant shift in the causes of death over the past decade; cardiovascular problems and cancer have replaced infectious and parasitic diseases as the leading causes of death.**¹¹ Reported deaths due to infectious and parasitic diseases have continued to drop over the past 10 years and now reportedly constitute only about 1 percent of all deaths (Table 1.7). At the same time, deaths due to cancers and cardiovascular diseases increased by 58 percent and 43 percent respectively, between 1993 and 2003. Cardiovascular diseases and cancers now account for about two-thirds of all reported deaths and are the leading causes of death among the adult population. Adult circulatory problem death rates are on par with those in neighboring countries, while cancer death rates remain below those of other SEE countries.¹² Lung cancer deaths account for one-fourth of all cancer deaths and are likely to increase in the years to come, given the high incidence of tobacco use. Road accidents resulted in 8.9 fatalities per 100,000 people in 2002 -- about the same level as in Macedonia, but lower than in other South East European countries. However, Albania's traffic death rate per driven kilometer is among the highest in the region and is likely to become a major public health issue as vehicle density increases. Albania has one of the lowest suicide rates (2.1 per 100,000 people) in the European region.

19. **Infectious diseases remain a major cause of death among children.** Acute respiratory infections and diarrheal diseases continue to be a major cause of child death. Whereas violence was a major cause of deaths for adolescents and young adults (mainly males) in 1996-1997, car accidents now appear to constitute the major problem.

¹¹ The causes of deaths are analyzed from the deaths forms using the Standard International Classification ICD9.

¹² Comparisons of death rates with other countries must be interpreted with caution, due to limited reliability of data.

Table 1.7 - Main Causes of Death, 1993 and 2003

	1993		2003	
	Deaths per 100,000 people	% of all deaths	Deaths per 100,000 people	% of all deaths
Total Deaths	543		574	
out of which				
Infectious diseases	11	2	3	1
Diseases of the circulatory system	201	37	288	50
Neoplasms	61	11	95	17
Diseases of the respiratory system	72	13	33	6
Diseases of the digestive system	21	4	10	2
Accidents, Injuries, Poisoning	48	9	39	7
Diseases of the nervous system	22	4	15	3
Ill-defined conditions	72	13	65	11

Source: Ministry of Health.

D.3. Morbidity and Epidemiological Profile

D.3.1. Infectious Diseases

20. **Infectious and parasitic diseases no longer present a major cause of mortality, but remain a significant morbidity burden. Vaccine preventable diseases appear largely under control.** After the last outbreak of polio in 1996, Albania was declared a polio-free country in 2002. The last nationwide measles epidemic took place in 1989-1990. Measles has since continued to circulate, with sporadic and limited outbreaks, but causing no deaths. The Government's National Vaccination Program aims at completely eradicating measles by 2010. If cases of diphtheria, pertussis, tetanus, and rubella continue to be reported, the annual incidence of these diseases is close to zero. Mumps still circulates, but the Government has introduced MMR vaccination (replacing MR) in 2005. After a drop in vaccination rates during the early- and mid-1990s, owing to budget crisis and civil unrest, reported vaccination rates have recovered to high recorded levels, thanks to the Government's commitment and to support from international agencies (UNICEF, WHO and GAVI). As Table 1.8 indicates, over 95 percent of children are reported to have been immunized against a range of infectious diseases. Two-course tetanus vaccinations for pregnant women are also reported to be in the 95 percent range. While the National Immunization Program has thus been successfully regaining its strength during the last 5 years, Albania's financial sustainability plan for the program points out that some problems need to be addressed. Among them are the need to more effectively measure and report population base figures (denominator) for vaccination coverage, a task complicated by widespread and frequent population migration; the need to reach out more effectively to migrant and minority populations in cities, and the need to further strengthen vaccination quality control. Box 1.2 spells out the goals and challenges of Albania's National Immunization Program.

21. **Zoonoses and parasitic diseases do not constitute a major disease burden, although the incidence of episodic diseases is increasing.** Brucellosis, for example, has been increasing significantly since the mid-1990s, pointing to the need for increased veterinary control of domestic animals and to close monitoring of the evolution of episodic diseases. No case of indigenous malaria has been reported since 1967, but leishmaniasis is still present.

Table 1.8 - Coverage Rates for EPI Antigens in Albania (% of age cohort)

	1998	1999	2000	2001	2002	2003
BCG	87	93	93	93	94	95
DTP-1			98	97	98	98
DTP-3	96	97	97	97	98	97
Hepatitis-B-3	94	96	96	96	96	95
Measles	89	85	95	95	96	94
OPV-3	97	97	97	97	98	97

Source: MOH/IPH, Albania, Financial Sustainability Plan for National Vaccination Program.

Box 1.2 - Albania's National Immunization Program

Objectives of the National Immunization Program

1. Achieving and maintaining 90 percent or higher vaccination coverage rates for each EPI antigen at all administrative units;
2. Introducing new antigens to the NIS, specifically mumps and Hib vaccines;
3. Developing and implementing immunization policies for high-risk groups;
4. Strengthening epidemiological surveillance and monitoring of EPI-targeted diseases;
5. Maintaining an effective cold chain system;
6. Reducing vaccine wastage rates to operationally possible levels;
7. Introducing presentation mix analysis for the vaccine supplies to ensure the most efficient vaccine prices and combinations;
8. Strengthening political commitment to EPI;
9. Strengthening the management and coordination of the EPI; and
10. Ensuring immunization safety and safe injection practices during immunization.

The National Immunization Program

Age	Visit	Vaccine					
		BCG	DTP	OPV	Hep-B	Hib	M(M)R
At birth	1	BCG-1			Hep-B-1		
2 months	2		DTP-1	OPV-1	Hep-B-2	Hib*	
4 months	3		DTP-2	OPV-2		Hib*	
6 months	4		DTP-3	OPV-3	Hep-B-3	Hib*	
12 months	5						MMR**
24 months	6		DTP-3	OPV-4			
5-6 years	7		DT	OPV-5			MMR**
14 years	8		Td				

* Introduction of Hib-vaccine is subject to availability of GAVI funding for which MOH plans to apply in September 2005.

** MR vaccine was administered until the end of the year 2004 and substituted by MMR vaccine starting in 2005.

Source: Ministry of Health/Institute of Public Health, Financial Sustainability Plan for the National Immunization Program, 2004.

22. **Although decreasing, waterborne diseases still constitute a significant public health issue.** Gastroenteritis, shigellosis, typhoid and paratyphoid diseases, and hepatitis A are present, due to the relatively widespread lack of basic amenities. Less than half of the population has access to piped water in their homes, there is no systematic monitoring of water quality, and the risks of water contamination from human waste are high.¹³ The last cholera epidemic (with about 2,000 reported cases) occurred in 1994. Most cases of diarrheal diseases are reported to affect the young. Given that these diseases mainly result from poor water quality and sanitary conditions, they are likely to affect the poor disproportionately.

23. **Albania's reported tuberculosis incidence is lower than that of other countries in the region and substantially below the average of lower middle income countries, but it has not significantly improved over the past decade.** The reported TB incidence has been averaging around 20 cases per 100,000 population over the past 10 years, although a slight decrease to 17.5 cases per 100,000 has been reported over the past 3 years. Overall, the TB incidence in Albania appears to compare favorably with that of other countries in the SEE region and is significantly below the wider European region average (46 per 100,000).¹⁴ However, the relatively high weight of extra-pulmonary TB indicates that there is a need to improve veterinary services. Overall, the TB prevention and treatment systems are judged to be weak, which calls for increased attention, particularly in view of the disease's linkages to HIV/AIDS and poverty.

D.3.2. Sexually Transmitted Diseases and HIV/AIDS

24. **Sexually transmitted diseases are underreported and no clear picture can be drawn from the available figures.** Despite some IPH efforts, no credible surveillance system for STDs is in place. Limited surveys suggest that STDs could have increased in the mid-1990s and might now constitute a public health problem. Migration is likely to be contributing to the increase in the transmission of STIs.

25. **Albania ranks low among HIV/AIDS prevalence rate countries, but it exhibits all risk factors that may lead to a rapid increase in the disease.** The reported incidence of HIV/AIDS (0.1 percent) is low, but underreporting is likely and there are indications that the incidence of the disease is on the rise. Sixty percent of the 116 HIV cases registered between 1993 and 2003 were reported after 2000, with 30 new cases reported between November 2003 and July 2004. Over 70 percent of notified cases are thought to have acquired the infection abroad and the main mode of transmission is heterosexual contact. Several contextual factors make Albania vulnerable to HIV/AIDS. The mobility of the population -- particularly temporary migration -- is facilitating HIV transmission. A UNICEF conducted rapid assessment showed that about 40 percent of sexually active migrants had sex with a sex worker abroad, and that more than 80 percent of them did not always use a condom. Albania is a source and transit country for women trafficked for sexual exploitation, and drug injecting is on the increase. HIV/AIDS awareness and knowledge are low and opinion leaders do not regard HIV/AIDS as an issue requiring immediate attention. Surveillance, prevention, and control activities remain limited.

D.3.3. Noncommunicable Diseases

26. **Information on the incidence and prevalence of noncommunicable diseases (NCDs) is extremely scarce, despite a marked increase in reported deaths due to such diseases.** Neither national nor international databases make it possible to paint a coherent picture of the incidence of NCDs in Albania. However, a key indicator of the overall increasing trend in noncommunicable diseases is the fact that standardized death rates for cardiovascular diseases and cancer have risen markedly over the past

¹³ Ministry of Health, Public Health and Health Promotion Strategy.

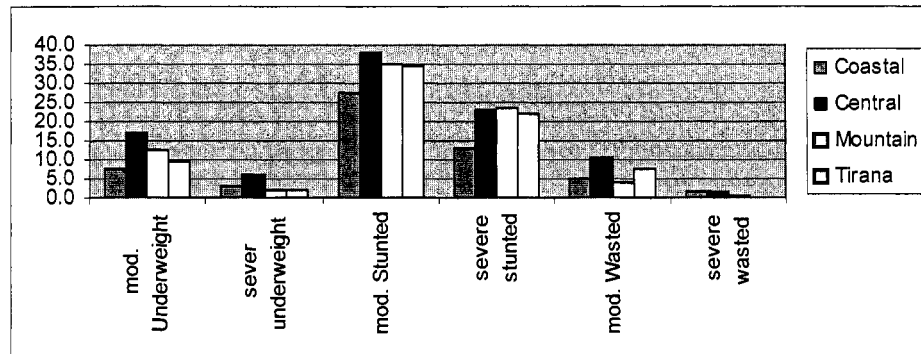
¹⁴ Figures based on WHO-HFA, 2005.

decade. A recent study shows a rapid increase in type II diabetes, with an overall prevalence of 6.3 percent and a peak of 8.3 percent among 55-64 year olds. These are double the figures for many Western European countries and reportedly twice as high as in the 1980s. By some estimates, the prevalence of diabetes can be expected to double again in the next 20 years.¹⁵ Given the rapid reported increase in deaths from NCDs and the indications of relatively rapid increases in the prevalence of diabetes, there clearly is a need to establish a better monitoring and reporting system for such diseases and to make efforts to improve physician capacity for early detection and disease management. Little information is available on the prevalence of mental health disorders and disability.

D.3.4. Nutrition

27. **Although they are spotty, survey data suggest a considerable incidence of malnutrition among Albania’s children.** According to the 2002 LSMS, almost one in three children is moderately stunted, while one in five is severely stunted. About 8 percent are moderately wasted, while about 1 percent is severely wasted. About 13 percent and 3 percent are moderately and severely underweight, respectively. UNICEF’s MICS found similar figures in 2000. The prevalence of malnutrition (for all three indicators) is highest in the Central region, but no clear pattern emerges in the other regions. Similarly, there appears to be little variation in the incidence of malnutrition among children from the lower three household consumption quintiles, but malnutrition, by all measures, is lower among the top two quintiles (Figures 1.8 and 1.9). Not enough is known to explain the relatively important incidence of stunting.

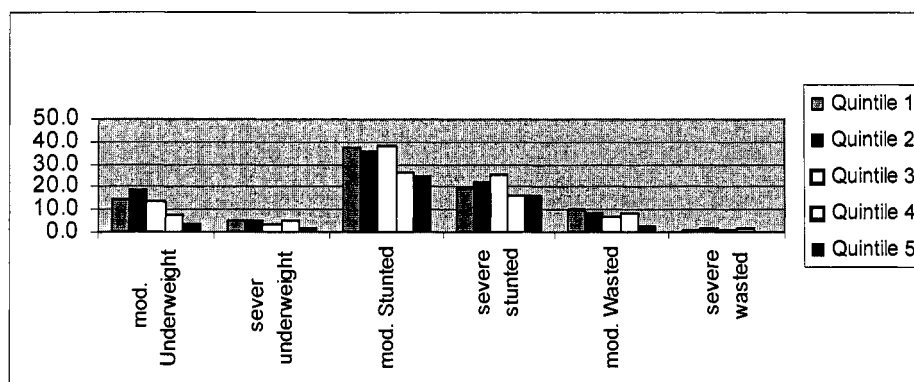
Figure 1.8 – Incidence of Malnutrition by Region



Source: LSMS 2002.

¹⁵ Ministry of Health, Public Health and Health Promotion Strategy.

Figure 1.9 – Incidence of Malnutrition by Household Consumption Quintile



28. According to the 2000 UNICEF MICS, only 9 percent of children under the age of 4 months are exclusively breastfed. At the age of 6-9 months, one-fourth of children are receiving breast milk and solid or semi-solid foods, and by the age of 20-23 months, only 6 percent continue to be breastfed. Approximately 3 percent of infants are estimated to weigh less than 2,500 grams at birth, a figure that does not vary much between urban and rural areas or by the educational level of the mother. About 80 percent of households use adequately iodized salt, but less than 50 percent of households in rural areas do so. According to the MICS results, vitamin A supplementation in under-five children is less than 8 percent, a low level.

D.3.5. Reproductive Health

29. **Despite relatively widespread awareness of contraceptive methods, only a small share of women use modern contraceptive methods. Knowledge of reproductive health issues is low among men and women.** The 2002 Reproductive Health Survey¹⁶ found that Albanian women demonstrate a relatively high awareness of both traditional methods (87 percent of women) and modern methods (90 percent of women) of contraception, but make relatively little use of modern contraceptive methods. Modern contraception is used by only 8 percent of married women and withdrawal remains the main method of birth control (by about 70 percent of married women). About 25 percent of married women declared not using any contraceptive methods. Female sterilization is reported by 4 percent of married women (15-44 years old), with condoms (2.1 percent) being the second modern method used. Only 1 percent of married women report using contraceptive pills. Not surprisingly, the level of awareness of contraceptive methods and the utilization of modern contraceptive methods is lower in rural areas and is correlated with the level of education. Less than one in five women and only one in ten men know when a woman is most fertile and only one in five women know that breastfeeding reduces a woman's fertility.

30. **While official figures point to a high prenatal care coverage rate, one in five women who gave birth between January 1997 and 2002 reports that she did not receive any prenatal care by health professionals.**¹⁷ This is one of the highest proportions in the European region, and is similar to Central Asian figures (for example, 1 percent in the Czech Republic and in Moldova, 4 percent in Russia,

¹⁶ Albania Reproductive Health Survey 2002 (final report-draft April 2005): INSTAT and IPH, with the support of the Centers for Disease Control (U.S.), USAID, UNFPA and UNICEF.

¹⁷ Albania Reproductive Health Survey.

8 percent in Armenia, 11 percent in Romania, but 30 percent in Azerbaijan). The LSMS data also show that coverage with prenatal care is significantly lower in the mountainous region -- which has the highest poverty incidence -- than in the rest of the country, and that it is lower among the poor.¹⁸ Similarly, the LSMS figures show that the share of children who died under one year of age as reported by surveyed mothers is substantially higher in the mountainous region than elsewhere.¹⁹

31. **The quality of prenatal care is of serious concern. The reproductive health survey found that less than 10 percent of prenatal care provided is adequate and that 70 percent is inadequate.**²⁰ This is one of the highest rates of observed inadequate prenatal care in Europe and Central Asia (ECA). As a comparison, prenatal care was deemed inadequate in 53 percent of cases in Romania, 13 percent in Moldova, and 47 percent in Georgia. On the other hand, over three-quarter of pregnant Albanian women (77 percent) had at least one ultrasound examination. The utility of such examinations in an environment where the technical capacity of caregivers is generally low and the overall quality of care is deemed mostly inadequate is questionable.

32. **Findings from the survey indicate that 84 percent of births took place in a health care facility between 1997 and 2002.** Most women deliver in a district maternity hospital (71 percent), in Tirana Maternity Hospital (14 percent) or in a birth house or health center (8 percent). Home births are more likely in rural areas, among older women, among the least educated, and among those with no prenatal care. For the period surveyed, the rate of cesarean section deliveries was at a relatively high 13.4 percent.²¹ Only one in five women had a postpartum visit. Urban women and women with higher levels of education were more likely to have a postpartum visit than rural and less educated women. Women who delivered at Tirana Maternity were considerably more likely to attend a postpartum visit (31 percent) than women delivering at district maternity hospitals (19 percent) or other locations (11 percent). The survey indicates that 92 percent of women registered their newborns, but only 20 percent of them during the first week.

33. 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 and dropped to 34.4 in 1999. The reported absolute number of abortions dropped from about 36,000 in 1996 to 11,000 in 2003. Family planning is easily accessible for approximately 60 percent of women in Albania. Although family planning services are free of charge, the number of people, especially teenagers, receiving services is low, which may be related to the social and cultural barriers that exist in Albanian society and the need to improve the quality of care offered by these services.

34. **The findings of the reproductive health survey point to the overall poor performance of the maternal and child health care system.** If Albania strives to move closer to European levels for infant mortality, the quality of prenatal and obstetrical care, as well as the utilization of post-natal care must be substantially improved. While a relatively high share of births occur with the attendance of a health care professional, the quality of prenatal and obstetrical care is poor and only a small share of women have any postnatal care. In 2000, UNICEF found that many of the infant deaths could be attributed to poor sanitary

¹⁸ Albania Poverty Assessment.

¹⁹ The LSMS 2002 asked each woman of reproductive age about the number of children to whom she gave birth and whether each child was still alive. For those who died, the approximate age at death can be calculated, allowing for a proximate estimate of the rate of children who died below the age of one. This estimate shows that 4.9 percent of children under the age of one died in the mountainous region, compared to 1.3 percent in Tirana.

²⁰ Using the Kotelchuck index.

²¹ For reference, international evidence suggests that little improvement in birth outcomes occurs if the rate is higher than 7 percent.

conditions in hospitals with such basics as gloves not widely available and antibiotics not distributed to all districts.²² Similarly, a safe motherhood needs assessment conducted in five districts and six maternity hospitals by the International Medical Corps found that essential drugs for obstetric care were often missing and that the available drugs were sometimes used inappropriately. The equipment for maternal and neonatal care was missing and maintenance capabilities were minimal. Delivery practices were substandard, health center midwives did not have the required skills to perform their tasks and were infrequently supervised.²³ Since the time of these surveys, relatively little effort has gone into improving the situation. The poor quality of prenatal and obstetrical care helps explain why an important share of infant deaths occur during the first week of life. High infant mortality rates and serious concerns with the quality of care for maternal and child health point to the need for concerted efforts to improve prenatal and post-natal care, as well as the quality of obstetrical care.

E. HEALTH RISKS AND DETERMINANTS

E.1. Life-Style Determinants

E.1.1. Smoking

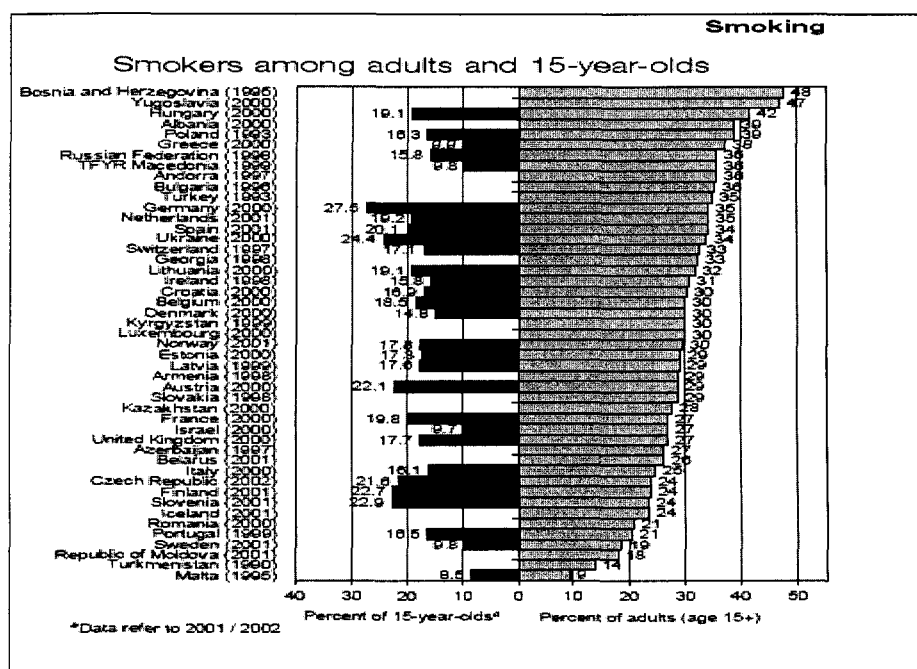
35. **Smoking has become a major health risk factor in Albania.** According to WHO/HFA data, 39 percent of adults in Albania are regular/daily smokers, far above the level observed in EU countries. The WHO tobacco country profiles shows a daunting figure of 60 percent of adult males being regular daily smokers. This is one of the highest ratios in the European region, just after the Russian Federation and Armenia. Smoking is less common among adult women than among men. The high smoking prevalence among adults is confirmed by surveys, but the comparability of data is limited owing to the use of different methods. While WHO data show that the total number of cigarettes consumed per person per year (at about 750 cigarettes) is among the lowest in Europe, the Economic Research Service found that per capita consumption of cigarettes was already at 2,150 in 1999 and at the average level observed in SEE countries. These data should be treated with caution as they are based on market figures and do not take into account the widespread smuggling of cigarettes. It is estimated that Albania spends about US\$260 million on tobacco each year. There are indications that smoking among the youth (and even among children) increased considerably after 1990. Surveys on limited samples show that about 90 percent of young people and 47 percent of children have tried tobacco, and that 65 percent of young people and 16 percent of children are addicted to it.²⁴

²² UNICEF, "Assessment of Social and Economic Conditions of Districts in Albania," Tirana, 2000.

²³ International Medical Corps, "Needs Assessment of Health Systems Infrastructure," Tirana, 1999.

²⁴ INSTAT, "Youth and Transition," 2003.

Figure 1.10 - Prevalence of Smoking in Albania and the European Region



Source: *Atlas for Health in Europe*, WHO, 2003.

36. **Zoonoses and parasitic diseases do not constitute a major disease burden, although the incidence of episodic diseases is increasing.** Brucellosis, for example, has been increasing significantly since the mid-1990s, pointing to the need for increased veterinary control of domestic animals and to close monitoring of the evolution of episodic diseases. No case of indigenous malaria has been reported since 1967, but leishmaniasis is still present.

E.1.2. Alcohol Consumption

37. **Unlike smoking, alcohol consumption is at a low level in Albania.** Average consumption of pure alcohol is 1.4 liter per year. This is 10 times lower than in Portugal and five times lower than in Germany. There are no indications on the trends in consumption and no data on the number of persons suffering from alcoholism and alcoholic psychosis. People drink wine and beer, but consumption of spirits is low.

E.1.3. Drug Use

38. **In the past decade, drug trafficking has increased and Albania is now recognized as a main transit country for cannabis, heroin, and cocaine smuggling.** It is estimated that 20,000 to 30,000 Albanians are using illicit drugs. Surveys have found that in the main cities (Tirana, Shkodra, Vlora, and Durres) about 4 percent of young people use drugs. However, the data available are not accurate enough and figures do not differentiate between users of “soft” and hard drugs.

E.2. Socioeconomic and Environmental Factors

E.2.1. Access to Water, Sanitation, Housing, and Power Supply

39. **Access to safe water remains a significant public health issue in Albania.** The LSMS data indicate that less than half of the population has access to piped water inside the house (Table 1.9). Less than 20 percent of rural dwellers have access to running water inside their dwelling and less than one in two has access to any running water, inside or outside their dwelling. On the other hand, in Tirana, virtually everyone has running water (97 percent) but most people think that this water is not of good drinking quality. Only 41 percent of rural dwellers have a toilet inside their dwelling, while 45 percent do not have any access to a piped toilet. Comparisons across regions indicate that the rural mountain region has the worst sanitation problems, while more than 90 percent of the Tirana population lives in dwellings with at least one toilet inside. However, even in urban areas, there is a serious risk of sewage water contaminating the water supply. It is estimated that, in Tirana alone, there are 24,000 connections between clean water pipes and wastewater pipes owing to breaks to the pipes.²⁵ Overall, the low level of access to piped water and adequate sanitation continues to pose a serious risk for epidemics of water-borne diseases in Albania.

40. The coverage of the electricity network is virtually universal. However, delivery of the service is still unreliable, and the situation is worse in rural communities. About 78 percent of the population reports daily interruptions, on an average of almost nine hours per day. International evidence shows a close correlation between the availability of electricity and infant mortality. According to the LSMS data, 12.5 percent of the population perceive their housing conditions as inadequate, mostly in rural areas (16.5 percent) but also in Tirana (8.5 percent).

Table 1.9 - Access to Water Across Regions

Main households water source (% of households)	Coastal	Central	Mountain	Tirana	Total
Running water inside	44.8	45.8	29.7	92.1	48.3
Running water outside	15.1	19.5	28.3	4.6	17.6
Water truck	0.4	1.5	0.3	0.1	0.9
Public tap	6.9	9.7	18.3	2.0	9.0
Spring or well	30.2	21.5	23.1	1.3	22.3
River, lake, pond	0.1	1.7	0.3	0.0	0.9
Other	2.5	0.3	0.0	0.0	0.9
	100.0	100.0	100.0	100.0	100.0

Source: LSMS 2002.

E.2.2. Solid Waste

41. **Only half of all citizens have access to solid waste removal services.**²⁶ The opening up of the economy has led to an increase in packaged consumer goods, which has increased pressure on the already weak waste management system, as has the rapid movement of rural populations into cities. When it is not removed, waste is left on the streets, where it attracts insects and animals that are vectors of

²⁵ MOH/IPH, Public Health and Health Promotion Strategy.

²⁶ MOH/IPH, Albania Public Health and Health Promotion Strategy.

communicable diseases. There are no managed dumpsites or incinerators. Solid waste removal is the responsibility of local governments and will require concerted efforts in the years to come, particularly in the main cities.

E.2.3. Roads and Traffic Volumes

42. **Road safety has become a serious public health threat.** Albania has the lowest rate of vehicles--66 per 1,000 people in the region (Croatia has 274 per 1,000; Macedonia has 170 per 1,000; and Bosnia has 114 per 1,000; and the traffic volume in Albania is still low by regional comparison (11 million vehicle kilometers per year, versus 44 million in Croatia, 27 million in Macedonia, and 24 million in Bosnia). However, road safety has become a considerable concern in Albania. Only 12 percent of roads are paved and only 8 percent of all roads can be considered good. Combined with limited signage, a high proportion of old vehicles in use and poor driving behavior, the low road quality leads to high road accident fatality rates (8.9 per 100,000).

F. CONCLUSIONS AND RECOMMENDATIONS

43. **Albania's health outcomes compare favorably to those of other middle-income countries, but lag behind those of other countries in the SEE region.** The political and economic transitions have not had a lasting negative impact on health outcomes. If some health indicators deteriorated in the early 1990s, all have by now at least returned to their 1989 level, and most have improved. However, most health outcome indicators do not compare well with the levels observed in the South East European region and are below the average of the European region. The many changes that occurred in the past 15 years have contributed to an accelerated demographic and epidemiological transition. As a result, Albania's health care system is faced with several challenges.

44. **The quality of maternal and child health care needs to be substantially strengthened if Albania strives to bring infant and maternal mortality rates close to the regional average.** Despite the dramatic reduction achieved in the past 50 years, infant, under-five and maternal mortality are still among the highest in the European region and reflect the low quality of prenatal, obstetrical and post-natal care rather than access to such care. Without substantial efforts to address the situation, Albania is unlikely to meet the related MDGs. Therefore, the improvement of maternal and child health should be a priority for public health action. Particular attention should be paid to maternal and child health issues in the mountainous region, which exhibits higher infant and child mortality rates than the rest of the country.

45. **Albania's health care system needs to shift its emphasis from almost exclusive focus on curative care to more preventive care and health promotion.** Albania's epidemiological profile is changing and the health care system is ill prepared to face the increasing incidence of noncommunicable diseases while also continuing to control infectious diseases. The latter are still prevalent and are a leading cause of infant and child deaths, but cardiovascular disease and cancer have become the leading causes of death among the adult population. They are expected to substantially increase as the population over 65 years of age doubles over the next 20 years. A significant portion of chronic disease conditions can be prevented through the promotion of healthy lifestyles, screening, and primary and secondary preventive care measures. Increased focus on preventive care is therefore becoming a high priority for Albania's health system. The main focus should be on strengthening the capacity for health promotion, as well as for primary and secondary prevention of cardiovascular diseases and cancer. This will require concerted action to build up the capacity of providers to adequately assess patient risk factors and to effectively manage the conditions of those exhibiting such risks.

46. **Although HIV/AIDS prevalence is reportedly still low, the risk of HIV transmission is high owing to the mobility of the population and human trafficking.** In this context, action should not only be directed to groups at high risk (drug users, commercial sex workers, male homosexuals, migrants) but it should also be combined with efforts to inform and educate the general population. Albania should also strengthen its surveillance capacity and build a second generation surveillance system, develop reference laboratories outside Tirana, and move to implement its HIV/AIDS strategy,

47. **Albania needs to strengthen its health information system to allow for informed policy decisions and monitoring of sectoral performance.** Good public health systems depend on ready access to routine information on health status, impending disease outbreaks, health risk factors, provider performance, and sectoral resource flows. The current status of the health information system, including basic data on health outcomes and health risk factors, is largely inadequate for appropriate sectoral performance monitoring and informed decision making. Health information has fallen short in both attention and financing in the past years. While there is an overall shortage of personnel with appropriate knowledge and skills in medical research and statistics, particularly at the district level, the IPH has a good basis and would be a natural body to assume responsibility for the collection and analysis of routine health information as well as for increased focused research efforts. Consideration should, therefore, be given to making IPH the core locus for health information and transferring all data collection and analysis responsibilities to this body. While IPH has already gained considerable experience working with various international partners in health information and health research activities, its capacity will need further strengthening to develop into a full-fledged body that can produce the data and analysis necessary to support a modern health sector. Developing a credible health information capacity will also require increased financial commitment from the Government. The recently established Public Health School could also become an important locus for the analysis of health information.

48. **The disease surveillance and monitoring system requires further strengthening.** The early warning system for outbreaks (Alert) is in place but needs to be strengthened on two fronts: first, by training and retraining the general practitioners who are acting as sentinels and reporting suspicious cases; and second, by reinforcing the capacity of the IPH to investigate these cases and provide the government authorities with reliable and timely information and advice.

49. **Efforts are also needed to curb the rapidly increasing tobacco consumption and fatal traffic accidents.** Tobacco consumption in Albania is high, and smoking is a major health risk factor. Past and current efforts to curb smoking appear inadequate. The health impact of tobacco use is likely to worsen in the years to come. Therefore, developing anti-smoking activities should be seen as a top priority for public action. International experience shows that only a multi-sectoral approach to the smoking problem and continued efforts can be effective. Similarly, the rapidly increasing traffic accident rate requires concerted public education efforts and coordination among the health sector, police, local governments and the Ministries of Transportation and Education.

CHAPTER 2: SUPPLY AND UTILIZATION OF HEALTH CARE

A. INTRODUCTION

50. This chapter will review the supply and utilization of health services in Albania. It draws on administrative data, data provided by the MOH for the purpose of this study and the 2002 and 2004 LSMS waves for the analysis of utilization of care. Appendix 1 gives further details about the LSMS data used in this chapter.

B. SUPPLY OF CARE

B.1. Supply of Outpatient Care

B.1.1. Planning and Management of Health Facilities and Public Health

51. Administratively, Albania is divided into 12 regions that include 36 districts, 65 municipalities and 309 communities. The health sector follows the same subdivision on a regional/prefecture and district level. Each prefecture comprises about three districts that are responsible for administering district hospitals, polyclinics and primary health care centers (PHC) through the regional or district public health departments, which are the MOH's local affiliates. Health care is supplied by a multitude of public and a limited number of private providers. The key public provider is the MOH. Other public Ministries (Defense, Education, and Justice) also provide health care services, but their capacities are limited.

52. **The MOH is the main provider of health care in Albania. It provides care through an extensive network of hospitals, polyclinics, and primary health care centers.** Specialized services such as obstetrics/gynecology and pediatrics are integrated within the PHC system. The Institute for Public Health (IPH) attached to the MOH, is responsible for health protection (e.g., prevention and control of infectious diseases, national vaccination), and environmental health; it mainly works through the district public health directorates. The directorates are accountable to both the IPH and the MOH. Local authorities are directly responsible for public health issues such as waste disposal, drinking-water supplies and some forms of environmental protection. Government sanitary inspections are the responsibility of the MOH. The MOH runs vertical interventions in national programs, such as child vaccination, reproductive health, epidemiological surveillance, HIV/AIDS, and the national program against tuberculosis. These programs are implemented with the help of health centers and health posts as well as promotional campaigns (e.g., against HIV/AIDS) at the national and local levels.

B.2. Availability of Outpatient Care

53. **A basic PHC system oriented towards the health of mothers and children was established prior to 1990 through a nationwide network of health centers and health posts.** Despite the expansive PHC network, however, the health care system prior to transition was secondary care-led and largely remains so today. Primary health care is provided through a network of health centers and health posts, supplemented by polyclinics in urban areas. Polyclinics are the responsibility of the district hospital or regional hospital with which they are affiliated and provide specialist care. Ownership of some primary care facilities in rural areas was transferred to the local governments in the mid-1990s. Ownership transfer of facilities housing primary health care in urban areas is ongoing. All primary health care facilities are, however, operated under the general administration of the MOH's regional and district

affiliates. The exception is the Tirana region. Under a decentralization pilot project, the Tirana Regional Health Authority was established to administer all PHC, including polyclinics and public health in the region.

54. In 1997, the government developed a PHC policy with planning standards that aims at securing one health post (ambulances) per village and a health center per commune, and to create PHC teams led by family physicians. Outpatient care in the public sector is provided in health centers, health posts, polyclinics and through home visits. Health centers are generally located in commune's administrative centers, and in smaller cities and villages. Health centers in rural areas have limited medical technology and a small number of beds, mainly for maternity care, though the bed occupancy rate does not exceed 10 percent. Health centers are staffed by one to three general practitioners (GPs) and nursing staff. In rural areas, a typical health center is staffed by one GP and two or three nurses, while a health post is staffed by a nurse or a midwife. Polyclinics are staffed by specialists as well as by GPs – the latter posted there to serve as the first point of contact for all patients coming to the polyclinic. Primary care teams led by GPs in PHC facilities are supposed to act as a gatekeeper for secondary care. However, bypassing is frequent due to the perceived low quality of care.

55. **The primary health care infrastructure was extensively damaged during the civil unrest in the 1990s and the process of facilities reconstruction is still ongoing.** The civil turmoil in the early and mid-1990s resulted in considerable damage to the primary care network, leading to a sharp decline in the number of operational facilities. In the last few years, there has been an intensified effort to renovate and update many PHC facilities, but about half of all health posts still remain nonoperational. To the extent that staff affiliated with these facilities are still at their post, they provide services from alternative locations, including their homes. In 2003, the MOH reported a total of 2,133 PHC facilities including 582 health centers, 1,501 health posts, and 50 polyclinics (Table 2.1). An estimated 700 health posts only are operational, although it is not known in how many cases personnel is operating out of alternative locations.

Table 2.1 - Number of Outpatient Facilities, 1995 and 2000-2003

Years	1995	2000	2001	2002	2003
Total population	3,185,000	3,113,000	3,132,000	3,150,000	3,169,000
Health Centers	622	580	604	571	582
No. of Health Centers /1,000 pop	0.20	0.19	0.19	0.18	0.18
Health Posts / Ambulances	1,832	1,505	1,433	1,375	1,501
No. of Health Posts /1,000 pop	0.58	0.48	0.46	0.44	0.47
Polyclinics with specialists, urban	53	50	50	50	50
No. of Polyclinics /1,000 pop	0.02	0.02	0.02	0.02	0.02
Total number of HC, HP, PC	2,507	2,135	2,087	1,996	2,133
Total HC, HP, PC /1,000 pop	0.79	0.69	0.67	0.63	0.67

Source: Ministry of Health, HNP at a Glance.

56. **There are marked regional variations in the availability and coverage of primary health care facilities.** Table 2.2 shows that the Central area has about 39 percent of the population and a considerably larger proportion of total PHC facilities (54 percent). Compared to their respective

population shares, the Mountain and Tirana areas are better served with polyclinics. The proportion of total PHC facilities in Tirana is smaller than the population share, mainly because of the under-representation of health posts; however, Tirana compensates for this difference through hospitals providing outpatient services. Similarly, there are large variations in catchment areas across regions, as demonstrated by Table 2.3.²⁷ On average, there are 5,274 people per health center, 2,045 per health post, and 62,638 per polyclinic, resulting in an average catchment area of 1,440 inhabitants per public outpatient facility, with significant inter-regional variations. Compared to WHO recommendations,²⁸ these catchment areas are relatively small.

Table 2.2 - Area Distribution of PHC Facilities, in % of Total, 2003

Area	Health Centers	Health Posts*	Polyclinics	All PHC Facilities	Pop
	<i>Total</i>	<i>Total</i>	<i>Total</i>	<i>Total</i>	<i>Total</i>
Central	46	58	35	54	39
Coastal	28	30	20	30	32
Mountain	11	5	12	7	10
Tirana	15	7	33	9	19
Albania	582	1,501*	50	2,133	
	100	100	100	100	100

Note: Only about 700 health posts are operational.
Source: Ministry of Health.

Table 2.3 - Population Catchment Area of PHC Facilities, by Region

Area	Regions	Number of inhabitants per PHC facility			
		Health Centers	Health Posts	Polyclinics	All PHC Facilities
Central	Berat	5,079	1,021	64,340	839
	Elbasan	5,668	1,570	90,684	1,213
	Gjirokaster	2,686	752	37,610	579
	Korce	5,765	1,128	53,036	927
	Shkoder	3,288	3,612	128,237	1,698
Coastal	Durres	16,345	2,452	122,590	2,096
	Fier	8,139	2,161	127,515	1,685
	Lezhe	3,061	2,067	53,061	1,206
	Vlore	3,860	1,892	96,491	1,253
Mountain	Diber	4,868	5,753	63,285	2,531
	Kukes	4,284	2,931	37,131	1,663
Tirana	Tirana	7,034	6,101	37,369	3,005
Average Albania		5,274	2,045	62,638	1,440

Source: Ministry of Health.

²⁷ In the absence of information on the number of actually functioning health posts, the information on total catchment area needs to be interpreted with caution, though figures on variability of catchment areas for health centers and polyclinics confirm the large variability in catchment areas.

²⁸ WHO recommends a catchment area of 10,000 to 15,000 inhabitants per health center with a physician; of 2,000 to 5,000 inhabitants per health post with nurse/midwife.

57. To some extent these regional differences are driven by the financial incentives set to providers. At the beginning of the transition, many physicians left rural and remote areas lured by more lucrative opportunities in tertiary hospitals and the private sector in the cities, especially Tirana. The introduction of new payments for the GPs, which included a capitation system with higher weights for rural and isolated populations, succeeded in attracting some GPs to rural areas but only with difficulty to the most remote areas. An estimated 1 percent of the population in 15 communities remain outside the MOH established norms for a GP. Almost half of this population is located in the Lezhe region. To limit the number of physicians working in cities, the Health Insurance Institute (HII) requires that contracted GPs in urban areas register at least 2,000 patients, compared to 1,700 patients in rural areas. The PHC policy developed in 1997 proposes that inhabitants should be free to register with the provider of their choice. The size of the catchment area and the number of registered people do not match, pointing to physicians over-reporting registrants to reach the minimum numbers set by the HII for capitation payment.²⁹ Another reason for the large variability is the significant internal and out-migration, which Albania has witnessed over the past decade.

B.3. Productivity of Primary Care Providers

58. **Utilization of primary health care facilities in Albania is low, leading to overall low productivity of physical and human resources in these facilities.** Table 2.4 shows great variability in productivity of health centers across regions, but points to overall low utilization. Some health centers in rural areas see as few as three patients per day. As shown in Chapter 3, the low utilization of health care facilities also leads to overall low productivity of health care staff, with the average primary care physician seeing only about eight patients per day, dropping to as little as an average of three patients in some regions. Assuming an average patient contact time of 20 minutes, this would suggest that the average primary care physician spends only about 2.5 hours per day seeing patients.

Table 2.4 - Number of Visits per Health Center per Day

Area	Regions	Health Centers	Number of Patients per GP per Day
Central	Berat	14	7
	Elbasan	10	7
	Gjirokaster	7	5
	Korce	22	9
	Shkoder	12	5
Coastal	Durres	43	7
	Fier	21	7
	Lezhe	5	5
	Vlore	12	10
Mountain	Diber	5	3
	Kukes	10	6
Tirana	Tirana	9	4

Source: Ministry of Health.

59. A more detailed review of productivity of outpatient care physicians in Tirana region shows that productivity among specialists is lower than among general practitioners, particularly in health centers (Table 2.5). Family physicians are slightly more productive than specialists indicating an oversupply of

²⁹ The total number of GP-reported registered patients is substantially higher than Albania's total population.

specialists. Others have found that productivity in PHC facilities in urban areas is significantly higher than in rural areas. Low productivity is related to overstaffing and underutilization in facilities, causing considerable increases in the overall average cost of a PHC visit to a health facility.³⁰ The large variation in availability and utilization of primary care facilities and staff points to an overall need to carefully revisit the primary care service standards and restructure service delivery in line with population distributions and needs.

Table 2.5 - Productivity of Physicians Working in Outpatient Facilities, by Facility, 2003

Facility Type	Location in Tirana Region	Number of visits per day per:	
		Family physician	Specialist
Health centers	Urban I	9.2	5.6
	Urban II	7.1	3.0
	Rural III	4.2	1.1
	Rural IV	5.4	1.1
	<i>Total</i>	6.7	3.3
Polyclinics	<i>Total</i>	11.1	6.5
Special Polyclinics	<i>Total</i>	n/a	1.8
Other Facilities	<i>Total</i>	n/a	2.7
Total Health Facilities		12.2	3.6

Source: Tirana Regional Health Plan. Annex L: Productivity of Primary Health Care Institutions.

C. SUPPLY OF INPATIENT CARE

C.1. Management of Hospitals

60. **The MOH is the owner and administrator of all hospitals, except the Military Hospital.** Public hospitals are headed by a chief head physician, who is in charge of overall hospital operations and management, but not trained to manage hospitals. As a result, many of them lack the management capacity required to effectively manage a modern hospital. Furthermore, they often continue to operate as physicians at the hospital or in private practice, thus decreasing the time and effort devoted to hospital management. Public hospitals have limited financial and administrative autonomy. All health personnel are recruited and assigned to specific hospitals centrally by the MOH, following norm-based requests by the head physician.

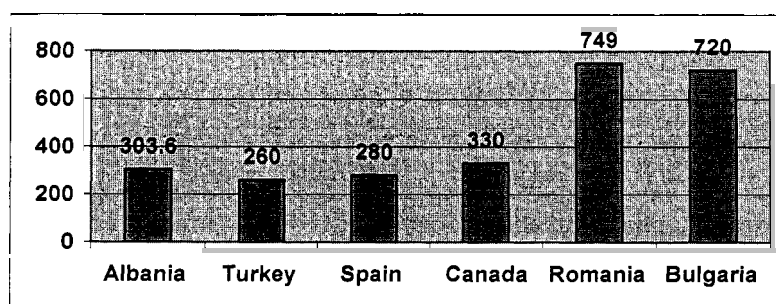
C.2. Availability of Inpatient Care

61. **Albania's hospital capacity (3.04 beds per 1,000 population) compares favorably to that of many other lower middle-income countries, but is on the lower end of the European scale.** There are 50 hospitals in Albania, of which 46 reported bed activity in 2003. With an average of 1.53 hospitals per 100,000 inhabitants, Albania reports similar hospital densities as Croatia (1.78), Hungary (1.76), Turkey (1.66), and Slovenia (1.4), but a considerably higher density than the Netherlands (1.2) and Sweden (0.9).³¹ While Albania has one of the lowest bed densities in the ECA region, several Western countries, including Sweden, Finland, Spain, and Turkey, report lower densities than Albania (see Figure 2.1).

³⁰ Fairbanks, A. and G. Gaumer, Organization and Financing of Primary Health Care in Albania: Problems, Issues and Alternative Approaches, PHR+, Tirana, 2003.

³¹ WHO Health For All database. <http://data.euro.who.int/hfad/>

Figure 2.1 - Hospital Beds per 100,000 Inhabitants, International Comparison, 2003



Source: OECD health data 2004.

Table 2.6 - Number of Hospitals and Hospital Beds in Albania, 1993–2003

Years	1993	1995	2000	2001	2002	2003
Hospitals	50	51	50	50	50	50
Number of beds / 100,000	275.7	319.2	326.3	328.1	313.7	303.6

Source: Ministry of Health, Albania Health Indicators for Years 1993-2003

62. **A decision to establish a three-tiered hospital network with district and regional hospitals and some tertiary care in Tirana has not yet been fully implemented**, as agreement could not always be reached on the downgrading of certain hospitals to district facilities and the upgrading of others. The three-tiered structure foresees 23 district hospitals located in the district center offering four basic services (Pediatrics, Obstetrics-Gynecology, Surgery, and Pathology), and 11 regional hospitals located in the prefecture centers offering specialized services in Ophthalmology, Orthopedics, Trauma, Neuro-Psychiatry, Chest Medicine, and Infectious Diseases, together with basic services. Tertiary care is offered in Tirana by the Tirana University Hospital, the Tirana Obstetric and Gynecology Hospital, the Lung Disease Hospital, and the Military Hospital. The latter is under the Ministry of Defense, specializes in traumatology and contains the university orthopedic department. There currently also remain nine rural hospitals, directly reporting to district hospitals and operating as an integral part of district hospitals. They offer Pathology and Pediatric services. Two psychiatric hospitals, located in Vlora and Elbasan, with 680 beds in total, specialize in the treatment of chronic and acute psychic patients. In addition to the tertiary hospitals, there are three specialized institutions: the National Center for the Well-Being and Development of Children, the VIP Clinic, and the Helicopter Center. The availability of hospitals and hospital beds varies considerably across regions, ranging from 0.78 hospitals per 100,000 inhabitants in Fier and Shkoder to 3.6 hospitals per 100,000 in Gjirokaster (Table 2.7).

63. **Consolidation of hospital departments would allow for efficiency gains. Several hospitals in Albania have identical departments within the same hospital or within close proximity.** For example, the Mother Theresa University Hospital in Tirana has four pathology departments, and several districts with two and more hospitals (e.g., Durres, Elbasan, Skrapar) have a pathology department in each hospital. Tirana has overall ten emergency departments in three hospitals with eight emergency rooms at the Mother Theresa University Hospital alone, an additional one at the Lung Disease Hospital and one at the Obstetric University Hospital. Emergency departments are costly, due to their resource intensity. Therefore, most OECD countries have only a small number of emergency rooms per city; for example,

Vancouver, Canada, with a population size similar to Tirana has only two emergency rooms for adults and one for children; similarly, Basel in Switzerland has three emergency rooms (one for adults, one for children, and one for OB/GYN). While physical dispersion of facilities may make merger of various departments somewhat difficult in the short term, appropriate planning for such mergers should be an integral part of developing an Albanian hospital map that would guide future investments in the hospital sector.

Table 2.7 - Regional Distribution of All Hospitals Providing Inpatient Care in Albania, 2003

Area	Regions	MOH Hospitals	Hospitals / 100,000	Hospital Beds	Beds/ 100,000	Total Staff per bed
Central	Berat	4	2.07	431	223.29	1.16
	Elbasan	6	1.65	1,071	295.26	1.00
	Gjirokaster	4	3.55	372	329.70	1.23
	Korce	4	1.51	835	314.88	1.05
	Shkoder	2	0.78	653	254.61	1.32
Coastal	Durres	2	0.82	544	221.88	1.74
	Fier	3	0.78	678	177.23	0.82
	Lezhe	3	1.88	334	209.82	1.62
	Vlore	6	3.11	831	430.61	1.02
Mountain	Diber	4	2.11	518	272.84	1.18
	Kukes	3	2.69	383	343.83	1.17
Tirana	Tirana Region	6	1.00	2,399	401.24	1.88
Total Albania		50	1.53	9,049	303.6	1.27

Source: Albania Health Indicators for Years 1993-2003 Ministry of Health.

C.3. Hospital Productivity

Hospital capacity has continued to increase over the past decade, despite falling admissions and shorter lengths of stay. Growing hospital capacity relative to the population, but falling admission rates and shorter average lengths of stay (ALOS) have led to a 10 percentage point drop in hospital bed occupancy since 1993. Over the past 5 years, the main hospital performance indicators including admission rates, ALOS, bed occupancy and bed turnover rates have remained on a similar low level (Table 2.8), pointing towards inefficiencies in production and idle resources in hospitals. Compared to other European countries, Albanian hospitals report relatively low rates for hospital admissions, surgeries, and bed occupancy. Resulting annual bed turnover rates in Albanian hospitals (29.4 in 2003) are markedly lower than rates for hospitals in Austria (46.9), Hungary (41.7), and the United Kingdom (56.8) in 2002.³²

³² OECD, Health Data 2004, 2nd edition.

http://www.oecd.org/document/30/0,2340,en_2649_37407_12968734_1_1_1_37407,00.html

Table 2.8 - Utilization of Inpatient Care Facilities in Albania, 1993–2003

	Years	1993	1995	2000	2001	2002	2003
Inpatient care admissions per 100 population per year		8.9	8.9	8.5	8.8	8.8	8.7
Average Length of Stay ALOS		12.2	9.1	6.9	7.0	6.7	6.6
Bed Occupancy rate %		63.0	63.0	52.0	52.8	53.1	53.6
Bed turnover rate		29.0	28.1	26.9	26.4	28.6	29.4

Note: Turnover rates show the number of patients per bed per year = (Number of available beds - Number of occupied beds) *(Number of days in study period)/ (Number of discharges in study period).

Source: Ministry of Health, Albania. Albania Health Indicators for Years 1993-2003.

64. **A large number of small hospitals with low utilization and occupancy rates point to an overall sub-optimal hospital structure.** Over 60 percent of Albania's hospitals are too small to exploit scale economies in the general acute care hospital setting. Thirty out of 46 hospitals have less than 200 beds. Together, these hospitals account for only one quarter of all hospital admissions. International evidence suggests that acute hospitals with less than 200 beds are too small to provide a full range of acute general hospital functions and achieve scale economies, while hospitals that have more than 600 beds are likely to display diseconomies of scale.³³ Only three hospitals in Albania have more than 500 beds, but these account for about 28 percent of all hospital beds and 30 percent of all admissions. The largest hospital, the Tirana University Hospital, reports the highest bed occupancy rate and accounts for almost 20 percent of all admissions in the country. Bed occupancy rates increase slightly in larger hospitals, while the ALOS is similar across hospital sizes and types, with the exception of the psychiatric hospitals (Table 2.9).

Table 2.9 - Distribution of Hospitals and Utilization, by Number of Beds, 2003

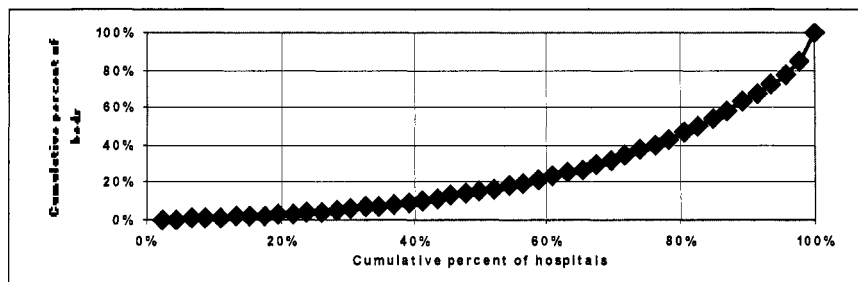
Bed range	MOH Hospitals		Beds		Admissions		Bed occup rate	ALOS
	Total	In %	Total	In %	Total	In %		
< 49 beds	11	23.9	331	3.7	5,392	2.0	26.7	6.7
50 - 99	9	19.6	728	8.0	16,000	6.0	34.5	5.6
100 -199	10	21.7	1,386	15.3	44,438	16.5	47.8	5.9
200 - 299	7	15.2	1,774	19.6	59,064	22.0	67.5	35.8 (*)
300 - 399	3	6.5	1,072	11.8	27,331	10.2	53.5	76.0 (*)
400 - 499	3	6.5	1,236	13.7	37,232	13.9	39.0	4.8
500 - 599	2	4.3	1,099	12.1	27,459	10.2	48.3	7.3
1,000+	1	2.2	1,423	15.7	51,609	19.2	74.4	7.5
Total	46	100.0	9,049	100	268,525	100.0	53.6	6.7

Note: (*) includes psychiatric hospitals with each having ALOS of more than 100 days.

Source: Ministry of Health, Albania. Albania Health Indicators for Years 1993-2003.

³³ Commission for Macroeconomics and Health. Working Group 5.

Figure 2.2 - Cumulative Proportion of Hospital Beds Across Hospitals



Source: Ministry of Health

65. **Smaller hospitals have low occupancy rates and a significantly higher ratio of staff per utilized bed than larger facilities, pointing to inefficient use of scarce resources.** Hospitals with less than 100 beds report occupancy rates that are substantially below those of larger hospitals. This reflects patients' failure to trust that these facilities can provide adequate quality of care. Insufficient human capacity and equipment in these small facilities lead people to circumvent small hospitals in favor of larger facilities. This in turn leads to two sets of inefficiencies. It causes unnecessary hospitalization of less severe cases at the more costly tertiary care level, and at the same time, leads to underutilization of facilities and human resources in the small hospitals. Hospitals with less than 50 beds have almost four staff per occupied bed and occupancy rates below 30 percent, pointing to high staff costs and low productivity. This compares to an average of about 2.5 staff for hospitals with 200 or more beds. Underutilization of small facilities also leads to concerns about the quality of care, which such facilities can provide. Low patient volumes lead to inadequate patient loads per practicing physician, in turn endangering the quality of care.

Table 2.10 - Hospital Staffing by Hospital Size and Characteristics, 2003

MOH Hospitals bed range	Bed Occup. rate	Staff per bed				Staff per <i>OCCUPIED</i> bed			
		Physicians	Nurses	Other	Total	Physicians	Nurses	Other	Total
< 49 beds	26.7%	0.14	0.55	0.34	1.03	0.52	2.07	1.26	3.85
50 – 99	34.5%	0.20	0.73	0.44	1.36	0.57	2.11	1.27	3.95
100 -199	47.8%	0.19	0.67	0.49	1.35	0.39	1.40	1.04	2.82
200 – 299	67.5%	0.17	0.49	0.52	1.19	0.26	0.73	0.77	1.76
300 – 399	53.5%	0.10	0.28	0.22	0.60	0.18	0.52	0.41	1.12
400 – 499	39.0%	0.21	0.53	0.57	1.30	0.53	1.35	1.46	3.34
500 – 599	48.3%	0.19	0.46	0.45	1.10	0.38	0.95	0.94	2.27
1,000+	74.4%	0.29	0.76	0.86	1.91	0.38	1.02	1.16	2.56
Total	53.6%	0.19	0.56	0.52	1.27	0.36	1.04	0.97	2.37

Source: Ministry of Health, 2003.

66. **Hospital occupancy rates vary considerably across regions, reflecting regional disparities in hospital capacity and varying utilization rates.** Six out of ten regions report occupancy rates below 40 percent. Only two regions, Lezhe and Diber in the mountainous area report occupancy rates above 50 percent. These are also the two regions which post the lowest utilization and productivity of primary care

doctors. This suggests that quality of primary care in these regions is of particular concern, leading the population to not seek care until hospitalization is required. This, in turn, can lead to significantly higher costs, both for the patient and for the health care system. The relatively short ALOS in most regions mirror to some extent the limited hospital capacity to treat less severe case mixes outside Tirana. At the same time, the relatively short ALOS in tertiary care facilities in Tirana suggest that a significant share of cases treated in these facilities may be basic cases, which do not require secondary or tertiary care.

Table 2.11 - Utilization of Inpatient Care in All Hospitals, by Regions and in Comparison, 2003

Area	Regions	Admissions/ 100 pop	All Deliv / 100,000	Surgeries / 100,000	Bed Occup. rate (%)	ALOS
Central	Berat	7.98	1,207.6	1,207.6	35.4	4.8
	Elbasan	6.35	1,638.9	1,451.5	40.4	17.6
	Gjirokaster	8.72	797.7	931.5	36.2	5.4
	Korce	7.01	1,200.7	1,017.0	37.0	6.3
	Shkoder	7.24	1,407.6	1,349.5	33.2	4.4
Coastal	Durres	5.97	1,377.0	1,101.6	44.7	4.9
	Fier	6.57	1,214.5	1,011.4	35.0	3.9
	Lezhe	7.63	1,542.3	733.8	52.4	6.3
	Vlore	10.56	1,281.5	1,622.4	42.1	39.9
Mountain	Diber	7.76	1,778.2	891.2	55.4	6.8
	Kukes	10.35	1,759.5	954.3	39.2	5.6
Tirana	Tirana	4.16	1,809.2	4,463.5	50.3	7.5
Total Albania (2003)		8.74	1,468.5	1,813.3	53.6	6.7

Source: Ministry of Health, Albania Health Indicators for Years 1993-2003.

Table 2.12 - Utilization of Inpatient Care Facilities, Country Comparison, 2002-2003

Country	Hospital beds / 100,000	Admissions/ 100 pop	ALOS	Bed Occ rate (%)	Surgeries / 100,000
Albania 2003	303.6	8.74	6.6	53.6	1,813.3
Turkey 2003	260.0	8.11	5.8	62.0	3,115.8
Romania 2003	749	24.92	n/a	n/a	17,065.3
Bulgaria 2003	720	17.54	n/a	n/a	n/a
Spain, 2003	280	11.94	9	77.2	5,252.1
EU 2002	795.8	18.55	9.5	76.9	7,200.7

Note: Other countries have acute care hospitals with higher level tertiary care that are not available in Albania, hence, their longer ALOS.

Source: WHO Health For All database. www.who.dk/hfadb

67. **Finalizing the country's hospital map is an important prerequisite to well guided future investments in the overall poor quality of Albania's hospital infrastructure.** While accessibility concerns must be taken into consideration, there is a need to carefully review Albania's hospital map and explore the possibility of closing some of the smaller facilities or turning them into outpatient facilities. Options to better organize the multiple departments with the same profile across a relatively small catchment area or at times even within the same hospital should also be explored. Furthermore, the decision to establish a regional hospital that would provide a substantial range of services in each regional prefecture also deserves further consideration, given Albania's limited resources to maintaining such a network. In view of the substantial remaining investment needs in the hospital sector, there is a critical

need to finalize the hospital map based on efficiency, quality assurance, and accessibility considerations; and then utilize this map to guide further investments in the sector.

D. SUPPLY OF PRIVATE SECTOR SERVICES

68. **Although still relatively small, private provision of outpatient services is growing.** Dental care and the pharmaceutical sector are largely privatized. The provision of other health care is still dominated by public providers, but the importance of the private sector is growing in the areas of diagnostics and outpatient services. Some private services are financed and organized by foreign NGOs, private agencies, or religious bodies. There are no private hospitals, though the Hospital Act allows for establishment of private inpatient facilities. International experience suggests that due to the high up front capital investments for hospitals, private hospitals in lower income countries generally require good prospects for regular operational funding through provider contracts with public or private purchasers.

69. **Private facilities are concentrated in the two largest cities, Tirana and Durres.** Most private sector facilities are well equipped and organized, tend to offer high technology diagnostic and treatment services, and better infrastructure than the public sector facilities. The MOH figures suggest that about 4,300 medical professionals work in the private health care sector, with dentists and pharmacists accounting for about one third and 45 percent respectively. Two-thirds of private doctor offices and diagnostic facilities are located in Tirana and Durres (Table 2.13).

Table 2.13 - Number of Private Outpatient Facilities by Regions, 2003

Type of Outpatient Care	Tirana	Durres	Other Regions	Albania
Total Number of Private Providers:				
No. of private outpatient facilities, <i>of which</i>	1,212	161	1,412	2,785
Doctor's office	402	29	195	626
Laboratories Diagnostic Centers	60	5	27	92
Dentists	376	61	533	970
Pharmacies, private	374	66	657	1,097
Total Private Providers per 1,000 Population:				
No. of private outpatient facilities, <i>of which</i>	2.03	0.66	0.63	0.91
Doctor's office	0.67	0.12	0.09	0.20
Laboratories Diagnostic Centers	0.10	0.02	0.01	0.03
Dentists	0.63	0.25	0.24	0.32
Pharmacies private	0.63	0.27	0.30	0.36
Percent distribution across regions				
Total private outpatient facilities	44%	6%	51%	100%

Source: Ministry of Health

70. **Anecdotal evidence suggests that the incidence of private care provided by publicly employed physicians is considerable and may be growing, although public sector physicians and nurses are not allowed to operate in private practice,³⁴** The 2004 household survey data found that somewhat over 10 percent of those who sought outpatient care did so from a private provider, although

³⁴ Doctors at the University Hospital are allowed to also engage in private practice.

official statistics point to only 626 private outpatient doctor's offices and 907 licensed private physicians, compared to over 2,100 public outpatient facilities with over 4,000 medical staff. The Government's Health Sector Strategy foresees that much of primary care could, in the medium- to long-term, be provided through independent primary care physicians or groups of independent physicians. Overall, the private sector can be expected to play an increasingly important role in the provision of health care as the economy grows and the health system further develops. Box 2.1 spells out several preconditions for successful private sector involvement in health care delivery.

Box 2.1 - Factors Affecting Private Sector Development in Health Care

Three factors must be in place to support effective public policy towards private health care providers in a health system: (i) policy makers must have knowledge about private sector capabilities, activities, and finances; (ii) there is an ongoing dialogue between public and private stakeholders to improve policy formulation; and (iii) there are institutionalized policy instruments for interacting (especially financing, regulation and dissemination of information) with the private sector and ensure that the latter contributes to overall health policy objectives.

Strategies to increase the contribution of the private sector to health objectives include: (a) harnessing the existing private sector in form of contracting, regulation, outreach mechanisms (information dissemination and education); or paying financial subsidies to providers (especially NGOs) that predominantly serve the poor, or operate in areas inhabited by the poor; (b) supporting the growth of the private sector to contribute to critical sector objectives in targeted areas through contracting, subsidies and a regulatory framework; and (c) converting/privatizing public providers to private sector providers.

Source: Harding, A. (2001): Private Participation in Health Services Handbook. World Bank.

71. **Albania's regulatory framework is inadequate to properly harness the benefits of private sector health care providers.** The health care sector is characterized by asymmetry of information, which leads to market imperfections. Consumers of health care services have insufficient information and technical knowledge to judge whether they are provided with the adequate amounts, types, and quality of care. Therefore, there is a role for government to regulate private sector activity, so as to ensure patient safety and minimal standards of care. This includes, among others, the licensing of providers, accreditation and inspection of facilities, establishment of reporting requirements, and the development of pricing policies for private care. Most of these functions are still ill developed in Albania. Although private providers in Albania must have a license to operate, the system is not always enforced; and the MOH has had difficulty developing and enforcing standards to ensure adequate quality of care and ultimately patient safety. Furthermore, neither the MOH nor any other body maintains an adequate database on private providers. There is overall insufficient information on private sector activities in the health care system and the capacity to monitor such activity is largely absent.

72. **As public providers are granted increased autonomy and the private sector further develops, Albania will need to put in place a strong regulatory framework and set up mechanisms to ensure quality control.** A supportive regulatory framework for private provision of health care is critical to ensure that the private sector helps meet overall sectoral goals such as improved health outcomes, efficiency, and cost containment. An effective system of safety, quality regulation, and inspection is needed to ensure adequate standards of quality for equipment and facilities, and in particular, to protect patients and staff from hazardous practice. A variety of regulatory mechanisms are available, and the appropriate selection depends largely on the regulatory objectives, available financial and human resources, and the level of technical expertise in the country. Aside from legislation and regulations, provider licensing, accreditation and certification systems are core tools, which countries use to regulate

private (and increasingly also public) provision of health care. Independent regulatory agencies and professional bodies can play an important role in this area.

Box 2.2 - Licensing and Accreditation of Health Care Providers

Accreditation is a means to systematically promote the continuous improvement of health services quality. Accreditation combines internal improvement and assessment with external assessment mechanisms, and uses a set of standards, specifically designed or adapted for a country's need. Hospitals may request accreditation of an international accreditation agency, but most countries prefer to develop their own system by adapting existing models and standards for services. Various types of health care providers can be subject of accreditation: hospitals, primary care centers, GP offices, etc., and specific activities or departments can also be accredited (e.g., laboratories). In most accreditation systems, providers do their own internal assessments, working continuously to reach the required level (standard) of care, while an accreditation body provides periodic external assessment and grants accreditation status to the surveyed provider. The status may be with or without conditions; for the standard period or for a limited period. The latter case would specify needed improvements. Various models exist – mandatory or voluntary, public or privately organized – and countries may have more than one accreditation body (e.g., separately for PHC and hospitals). Many accreditation bodies also provide training for quality management staff at the provider level as well as for external surveyors.

Standards of services delivery are periodically upgraded to match the development of the health sector in general and medical and nursing science and practice in particular. Standards can cover all aspects of health care provision, i.e., the physical and human resources infrastructure, the management and administration, organizational components, various processes (clinical and administrative), as well as the desired outcomes of the care process. If clinical practice guidelines are developed and endorsed, they should be referred to in the accreditation standards. International experience indicates that financial and institutional questions need to be dealt with up front to ensure that investments in the development of an accreditation system are not in vain. Some countries have realized that the running costs for an accreditation system could not be mobilized after making the establishment investments.

Successful introduction of quality improvement mechanisms in general and accreditation systems in particular also call for: (a) raising awareness about the importance of continuous quality improvement among the hospital staff and patients; (b) active involvement of hospital management in the quality improvement process, (c) appointment or designation of special staff in the hospitals to deal, on a daily basis, with quality issues and to assist in the preparation for the internal assessment as well as for the external survey; (d) training a sufficient number of external surveyors (eventually preceded via a train the trainers program); (e) providing a legal framework; and (f) involvement of the Health Insurance Fund or other purchasing agency.

With a licensing system, a governmental authority grants permission to an individual practitioner or a health care organization to operate or to engage in an occupation or profession-based on minimal standards. The development of a strong licensing system, based on transparent licensing standards to ensure a minimum level of hospital care would generally proceed the development of an accreditation system, which aims at continuous quality improvement.

73. **Albania has already undertaken substantial work on the establishment of quality standards for hospitals and initiated work towards the establishment of a hospital accreditation system.** With the support of WHO, it has developed a total of 252 standards, which cover the main domains of hospital functioning. The MOH has also developed various monitoring indicators, which, together with the standards, form an instrument for external assessment of hospitals and a basis for establishing an accreditation program. The standards are currently piloted in four Albanian hospitals (Berat, Lezha, Durres, and Lung hospital in Tirana), with results expected by the end of July 2005. The MOH also plans to establish an accreditation body, starting with an in-house office, which later could be made more independent and moved out of the MOH. The achievements to date are indeed an accomplishment.

However, before a final decision on the appropriate mechanism to ensure quality control in the Albanian context is taken, a number of key questions need to be answered, including, whether the financial and human resource capacity to support an accreditation system are available (see Box 2.2)

74. **As a first priority, the provider licensing system should be substantially strengthened so that it can serve as an instrument to ensure higher quality of care.** This will require swift action to develop appropriate licensing standards. Consideration should also be given to introducing a certificate of needs procedure for high-end equipment and for high-risk procedures. This could help support explicit and well informed decision making about such investments and to carefully plan for the introduction and distribution of such medical technology, which in turn will be essential for cost containment.

E. UTILIZATION OF HEALTH CARE

75. **Administrative data suggest that Albanians have significantly less outpatient contacts with health care providers than the people of other countries in the ECA Region.** Table 2.14 shows the average annual visit rate to PHC health facilities in the public sector decreased from 1.8 in 2000 to 1.6 visits per capita in 2003. This may partly be a reflection of growing, albeit still small, utilization of private outpatient facilities by those frustrated with the low quality of care provided in public facilities. Albania's per capita outpatient visit rate is considerably below the average visit rates reported in the ECA, and Latin American Caribbean region. It is also below values reported in nearby Macedonia and Turkey, and Finland, one of the most efficient European health systems (Figure 2.3).

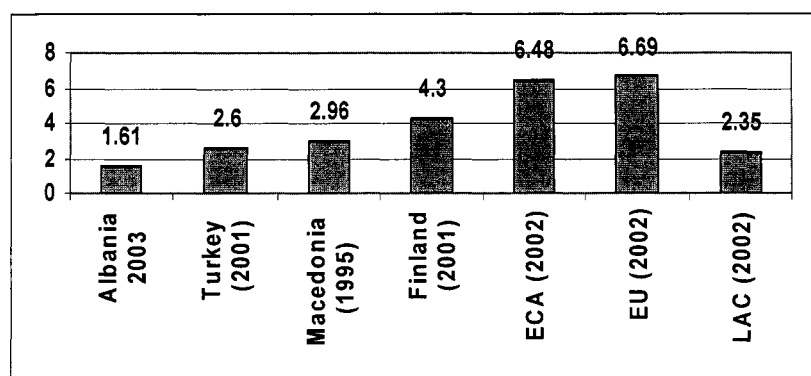
Table 2.14 - Utilization of Outpatient Care in Albanian PHC Facilities, 2000-2003

PHC visits	Years			
	2000	2001	2002	2003
Total visits, in thousands	5,547	5,524	4,835	5,099
Visits per capita / year	1.78	1.76	1.53	1.61
Total visits / facility / day (300 workdays)	8.66	8.82	8.07	7.97*

Note: Visits/facility/day based on all reported facilities.

Source: Ministry of Health.

Figure 2.3 - PHC Visit Rates per Capita per Year, Country Comparison



Source: World Bank, HNP Statistics, <http://devdata.worldbank.org/hnpstats>.

76. **Outpatient utilization varies considerably across regions.** Visits range from 3.2 visits per capita per year in Durres to less than one visit in Diber and Elbasan. Interestingly, Durres, which shows the highest contact rate per capita overall, shows the lowest per capita visits to polyclinics, resulting in substantially higher workloads of primary care physicians and less idle primary care capacity in this region than anywhere else. This may partly be a reflection of the health insurance pilot project with Durres Hospital resulting in better gate keeping functions of GP providers than elsewhere. On the other hand, the data also point to the failure of the gatekeeper function of the primary health care system in Tirana region where 80 percent of contacts are at polyclinics, despite concerted efforts to upgrade the primary care infrastructure. The highest annual visit rates are reported in the two regions with the largest catchment areas, Durres and Tirana, suggesting that larger catchment areas do not negatively affect access to care. The reported higher contact rates in Durres and Tirana are likely to be even higher, given the comparatively high presence of formal private providers in these cities. They may also reflect higher health insurance coverage and an overall lower likelihood of having to pay for outpatient care in these cities than elsewhere in the country (see Chapter 5).

Table 2.15 - Number of PHC Visits per Capita per Year, by Region and Health Facilities, 2003

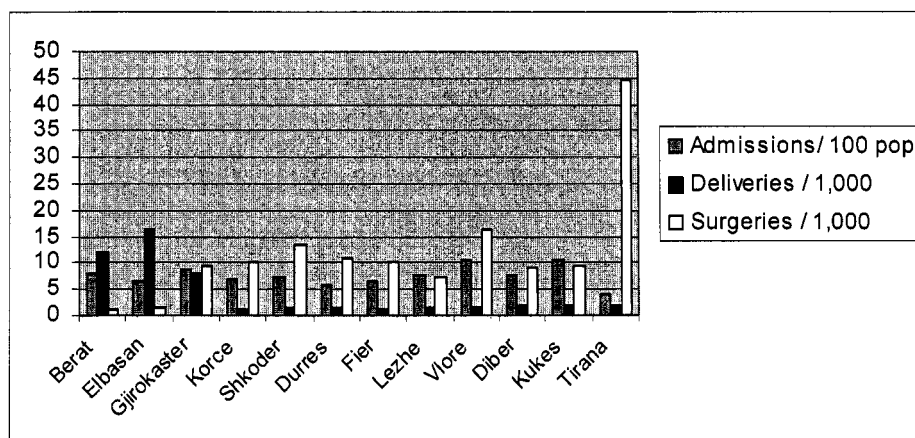
Area	Regions	Health Centers	Health Posts	Polyclinics	Home visits HC	Home visits HP	Total visits
Central	Berat	0.80	0.22	0.38	0.02	0.01	1.43
	Elbasan	0.53	0.13	0.32	0.01	0.01	0.99
	Gjirokaster	0.86	0.09	0.51	0.01	0.00	1.49
	Korce	1.13	0.28	0.57	0.03	0.01	2.02
	Shkoder	1.10	0.45	0.30	0.16	0.05	2.07
Coastal	Durres	0.78	1.37	0.24	0.02	0.75	3.16
	Fier	0.77	0.27	0.48	0.02	0.01	1.56
	Lezhe	0.47	0.14	0.72	0.02	0.03	1.39
	Vlore	0.93	0.18	0.32	0.03	0.01	1.47
Mountain	Diber	0.29	0.18	0.31	0.03	0.01	0.82
	Kukes	0.71	0.04	0.25	0.06	0.01	1.06
Tirana	Tirana	0.39	0.07	1.78	0.01	0.01	2.26
Annual visits per capita		0.70	0.28	0.67	0.03	0.07	1.75

Source: Health Indicators for Years 1993-2003, Ministry of Health.

E.1. Utilization of Inpatient Care

77. **Although at the lower end of the European scale, Albania's inpatient admission rates are similar to those in other SEE countries.** Inpatient admission rates appear to have remained relatively stable over the past decade, despite the upheavals during the early and mid-1990s. There are marked regional variations in hospitalization rates (Figure 2.4). The substantially higher incidence of surgeries in Tirana suggests that a large share of the population from across the country travels to the capital for hospital treatment, as the relevant services are not available or the quality deemed inadequate in hospitals nearby.

Figure 2.4 - Hospital Service Utilization Per Capita, Across Regions, 2003



Source: Ministry of Health.

E.2. Demand for Care Based on Household Survey Findings

78. This section examines the utilization of outpatient and inpatient care based on the household survey data from the LSMS 2002 and 2004. The analysis provides additional information on the socio-demographic and economic background of individuals who are sick and who seek care. To circumvent any self-selection issues among sick individuals, the analysis examines utilization based on all individuals, as well as by including all sick individuals only. Results of the former are presented in the annex. To ensure highest comparability of the two data sets, the analysis is carried out using the panel survey set in 2002 rather than the full LSMS data set. The 2004 survey did not include any household income or expenditure information. Using the socio-economic status quintile variables that were identified in the LSMS 2002 to classify households interviewed in 2004 may cause implausible results as it assumes that households did not change their relative socio-economic ranking position since 2002. Therefore, the socio-economic analysis is limited to 2002 data. Reference to results from the full LSMS data is made where appropriate.

E.3. Self-reported Morbidity and Care Seeking in 2002 and 2004

79. In the LSMS 2002 about 16 percent of all individuals interviewed reported chronic illness during the three months before the interview and 14 percent had a sudden illness during the four weeks prior to the interview.³⁵ Women were more likely to report having been sick than men. Chronic diseases were reported more frequently among those who lived in urban areas outside Tirana and in rural areas and among the non-poor. Sudden illness was most frequent among the rural population and the extreme poor.

80. In Table 2.16, utilizing the panel data for 2002 and 2004, shows that a higher proportion of individuals interviewed in 2004 report having had an illness than in 2002. This difference may be related to people finding it difficult to self-assess their health status and define their illness, specifically if they were not diagnosed by a health care provider, or not informed about the diagnosis. In both years, chronic

³⁵ See World Bank: Albania Poverty Assessment, November 2003.

and sudden illness was significantly more frequent among women than men; and rural individuals significantly more often reported sudden illness than urban groups.

Table 2.16 - Percent of Individuals with Chronic or Sudden Illness, by Gender and Age, 2002/2004

APS Year	Illness	Gender		Area	
		Female	Male	Rural	Urban
2002	Chronic	16.09**	11.96	14.05	14.16
	Sudden	14.89**	12.76	15.72*	10.33
	Total	26.62**	21.97	25.64*	21.95
2004	Chronic	25.92**	19.04	22.71	22.68
	Sudden	12.52**	5.15	11.08**	6.13
	Total	33.69**	21.73	29.21	26.46

Notes: For comparison with full LSMS sample 2002, see Albania Poverty Assessment, Table 5.4. Level of significance between urban/rural, female/male variables: * p-value<0.05; ** p-value<0.01.

Source: LSMS panel data 2002 and 2004.

81. **A lower share of those who reported being sick sought health care in 2004 than in 2002. Being covered by insurance increases the likelihood of seeking care.** Table 2.17 shows the proportion of individuals who had any kind of inpatient or outpatient contact (excluding dentist and pharmacists) by socio-demographic characteristics for the entire population and conditional on being sick. In both years, insured sick individuals reported a significantly higher contact rate than the sick uninsured.³⁶ The data also show a drop in care seeking among those who were sick, with a more marked drop among the rural population and the uninsured. These results hold regardless of whether all health care is included or only outpatient care. When only those who were suddenly ill are considered, the place of residence also had a significant impact on care seeking, with a substantially higher share of the urban population seeking care in both years.

Table 2.17 - Percent of Individuals with Any Kind of Inpatient or Outpatient Care

Year	Female	Male	Urban	Rural	Insured	Uninsured	All
<i>In percent of all individuals</i>							
2002	19.38**	14.35	16.01	17.31	22.06**	15.26	16.86
2004	18.44**	10.96	15.90	14.29	21.67**	8.31	14.94
<i>In percent of sick individuals</i>							
2002	38.61	38.48	37.48	39.12	44.84**	34.45	38.56
2004	34.50	30.94	34.20	32.47	39.41**	23.63	33.19

Level of significance between socio-demographic variables: * p-value<0.05; ** p-value<0.01.

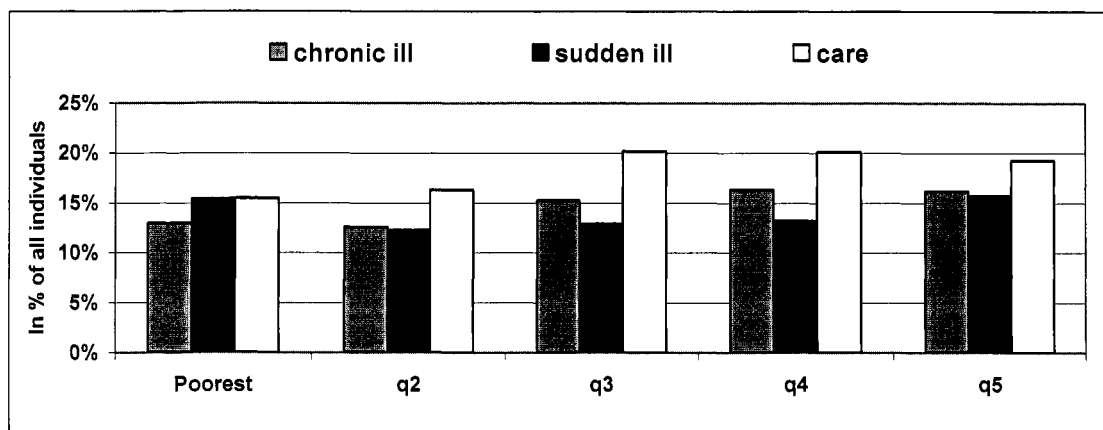
Source: LSMS panel data 2002 and 2004.

82. **Data from 2002 confirm that the likelihood of an individual seeking care increases with socio-economic status,** irrespective of whether the entire population is considered or only those who reported an illness. The data also show a higher reported prevalence of chronic illness among the upper income groups, which is likely to be related to better diagnosis and care seeking among the upper income

³⁶ In 2002, the question was asked whether an individual sought care over the past four weeks irrespective of his/her health status; while in 2004 the question was directly linked to the reported illness.

groups. Multivariate analysis confirms that the likelihood of an individual seeking care increases with income level, education level, and insurance coverage.³⁷

Figure 2.5 - Self-reported Illness and Care Seeking by Household Expenditure Quintiles, 2002



Source: LSMS, 2002.

E.4. Service Provider Location

83. The vast majority of those seeking health care do so in a public facility, but the utilization of private providers increased slightly between 2002 and 2004. Table 2.18 suggests that in both years, around 90 percent of the population sought care from a public facility. However, the share of those seeking private care increased for both chronically and acutely ill over the two-year period. This increase was mainly at the expense of those seeking care from a nurse.

Table 2.18 - Proportion of Individuals with Outpatient Care, by Health Status, 2002-2004

Individual has:	Whether Sought Care in Outpatient Facility			
	Public Facility	Nurse Care	Private Care	Both, Public and Private
Chronic Illness				
2002	90.32	17.75	12.20	8.29
2004	87.14	10.01	15.66	7.65
Sudden Illness				
2002	88.01	27.04	8.80	5.54
2004	88.62	14.92	11.00	5.08

Source: LSMS, panel data 2002 and 2004.

84. A significant share of those seeking care bypass primary care and seek care at polyclinics or hospitals. The 2004 data allows for more differentiation of public facilities and shows that over 40 percent of those who were sick sought care at a polyclinic or a hospital, rather than at the primary care

³⁷ Albania Poverty Assessment.

level (Table 2.19 and Annex 2.1). While the data do not allow to determine how many of those who visited the polyclinic self-referred, the data clearly point to an excessively high share of the population seeking care at higher order facilities, where they are more likely to incur out-of-pocket expenditures for travel and treatment. The data also suggest that among the acutely ill, those in rural areas and those without insurance are more likely to seek care at a polyclinic. Others have found that bypassing of primary care is extremely frequent, with close to half of the population going straight to the polyclinic or the hospital even for simple conditions like a cold or a flu. They also found that those in rural areas and lower income groups are more likely to bypass than others,³⁸ although the likelihood of having to pay for care was significantly higher at polyclinics and hospitals than at PHC centers.

85. **This suggests that the gate keeping system, which the Government expects GPs to exercise, is not working.** Lower income groups, those without insurance and those from rural areas seek care at higher order facilities, where they expect to receive higher quality care, facilities are better equipped and supplied and a broader range of services is offered. Low per capita visit rates to PHC facilities combined with anecdotal evidence suggest that most people who visit PHC providers simply do so to obtain HII reimbursable drug prescriptions, which only GPs can issue. For the 60 percent of the population who do not benefit from HII drugs benefits, the low quality of care available at PHCs make it worthwhile to spend more time and money to directly seek care at higher end facilities or from private providers. Focus group surveys showed that quality of care problems at the PHC level include the absence of equipment, drugs and medical supplies, insufficient technical capacity of health care personnel, the lack of cleanliness and poor physical conditions in health facilities.³⁹ Participants also suggested that quality of care tends to improve when informal payments are made. The same study also found that GPs often refer patients to higher order facilities because they are not allowed to or lack the necessary skills to provide a particular service.

Table 2.19 - Location of Care Seeking for Persons Reporting Sudden Illness, 2004

	Prevalence of Sudden Illness	Type of provider during 4 weeks prior to interview				
		Private provider	Public clinic	Polyclinic Hosp OPat	Inpatient Hospital	Pharmacy
Female	12.52**	7.22	40.66	36.55	4.25	11.32
Male	5.15	11.03	38.75	41.77	5.85	2.60
Urban	6.13	4.88	45.49	32.71	4.02	12.90
Rural	11.08**	9.75	37.57	40.33	4.94	7.42
Insured	9.75	10.60	46.20	26.70	7.07	9.43
Uninsured	8.41	4.92	32.38	52.26	1.47	8.97
<i>Pearson Chi2(4) = 11.042; p<0.05</i>						
Total	9.07	8.13	40.2	37.80	4.63	9.23

Level of significance: * p-value<0.05; ** p-value<0.01.

Source: LSMS panel data 2004

³⁸ Hotchkiss et. al. (2004)

³⁹ ACHO (2003): Considering Health at the Local Level: Results of a Qualitative Stakeholder Assessment in Albania. Final Report.

E.4.1. Hospitalization

86. **Self-reported hospitalization rates in Tirana are lower than in the rest of the country.** In 2002, about 4 percent of all individuals interviewed were hospitalized during the year before the interview. The full 2002 LSMS data showed that people in the Tirana region reported lower rates of hospitalization (2.5 percent) than those in other cities (4.7 percent) and those in rural areas (4.6 percent); a finding that was also supported by other surveys that found that rural households were more likely to seek hospital care than urban households.⁴⁰ Table 2.20 (utilizing the panel data set only) shows that hospitalization was more common among women than men and among the insured than the uninsured in 2004.

Table 2.20 - Proportion of Hospital Stay, by Socio-demographic Characteristics, in Percent of All

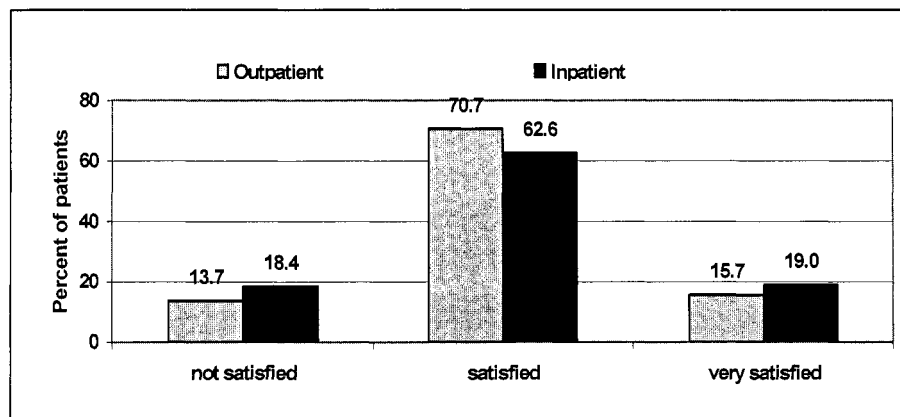
Year	Female	Male	Urban	Rural	Insured	Uninsured	All
2002	4.83**	3.27	3.85	4.19	3.61	4.31	4.07
2004	5.20*	3.71	5.00	4.16	6.58**	2.45	4.50

Level of significance between socio-demographic variables: * p-value<0.05; ** p-value<0.01.
Source: LSMS panel data 2002 and 2004.

E.4.2. Satisfaction with Hospital Care

87. **Although the majority of the population is satisfied with the care received, one out of five hospital patients is dissatisfied.** In 2004, the majority of patients were satisfied or very satisfied with hospital inpatient and outpatient care, while about 15 percent was not satisfied at all. There was no difference in satisfaction across socio-demographic groups. Patients who were not satisfied identified four specific issues including overall poor quality of hospital care, dirtiness in hospitals, long waiting hours, and lack of drugs. Of the individuals with unsatisfied inpatient or outpatient hospital care, 10 percent and 20 percent, respectively judged the price they had to pay (formal and informally) as too expensive.

Figure 2.6 - Satisfaction with Inpatient and Outpatient Hospital Care, 2004



Source: LSMS panel survey 2004.

⁴⁰ See Hotchkiss et al. (2004)

E.4.3. Reasons for Delaying Care Seeking or Being Excluded from Care

88. **At least one quarter of those who do not seek health care when sick delay care seeking because they can not afford it.** Of all individuals interviewed in 2002, about 5 percent mentioned *having delayed seeking care* when sick, which was equally common across socio-demographic and economic groups. Asked about the reason, 44 percent thought their health would improve without care, while 27 percent could not afford seeking care. For 26 percent, the distance to the health facility was a barrier. Non-affordability was mentioned by 65 percent of the “poorest delayers,” compared to 9 percent among the “better-off delayers,” with the latter most likely complaining about the distance barrier. This puts the “distance question” into a different perspective, suggesting that the better-off are more demanding about how close to their house the next health facility should be; whereas, financial barriers created by formal and informal fees are the constraints in access to care for low-income groups. The 2004 data suggests that non-affordability and distance were less important determinants for not seeking care, while the share of those who thought their condition was not serious increased.

89. **One-half of those who do not seek hospital care when referred to a hospital, do not go because they can not afford it.** In 2002, about 5 percent of all individuals had been referred to a hospital during the past 12 months, but they did not go. Not following hospital referral is equally likely across socio-demographic and -economic groups, as are the reasons for doing so, with 50 percent mentioning the price for care as the major barrier, followed by the hope that their health would get better (20 percent).

90. In 2002, about 1 percent of all individuals reported having been refused care by a health care provider, which was mainly related to individuals not being able to pay (75 percent) or because the health facility is only for residents living in the catchment area. About 53 percent of all individuals were *entitled to a drug discount*, which is significantly ($p < 0.01$) more likely among the better-off, the insured, and rural groups. However, about 23 percent of those who are entitled could not benefit from their right when they needed drugs. Exclusion from drug benefits was significantly more likely among rural than urban individuals ($p < 0.05$), and the uninsured ($p < 0.001$). Administrative reasons appear to be the main barriers for individuals to access their drug benefits with 56 percent of those who were excluded from benefits, not having received the document identifying them for entitlement. An additional 17 percent could not benefit from drug discounts because drugs were not available.

F. CONCLUSIONS AND RECOMMENDATIONS

91. **Albania’s public provider network suffers from considerable inefficiencies which are reflected in low productivity at all levels of care.** Utilization of outpatient care is low compared to other countries, resulting in an underutilized health system and idle resources. Outpatient visit rates are lowest in Mountain areas and in the Elbasan region; as well as in health posts throughout the country. Utilization of care is less likely among low-income groups, those without health insurance and those in the mountainous region, implying inequity in utilization and access to care. A large share of those who seek care do so in higher order facilities in search of perceived higher quality, although this implies higher out-of-pocket spending and traveling longer distances. Those in rural areas, lower income groups and those without insurance coverage are more likely to bypass PHC than others. There are substantial inter-regional variations in PHC catchment areas, but larger catchments do not imply lower per capita utilization, suggesting that there is room to enlarge catchments, while upgrading the quality and scope of services provided in PHC facilities which serve larger areas.

92. **The primary care network needs to be better aligned with demand for such care.** Overall, there is a need to better align the supply of infrastructure, equipment, and human resources with the population's health needs by means of developing regional PHC maps, which reflect current population distributions, existing and expected demand for care and aspired efficiency improvements. International evidence and initial experience with USAID-supported activities in Albania suggests that PHC productivity can be substantially increased if the skills of PHC provider staff are upgraded, facilities better stocked with supplies and equipment, and the scope of services offered broadened.

93. **The preparation and adoption of a hospital network masterplan is a key prerequisite to well guided future investments in the hospital sector.** The hospital network is characterized by a large number of small hospitals with low occupancy rates, as patients circumvent these hospitals for want of quality. Six out of 12 regions have hospital occupancy rates of less than 40 percent, while only Tirana, Diber, and Lehze show occupancy rates above 50 percent. Hospital occupancy rates would be even lower if patients were not bypassing the PHC system and if hospitals did not have inadequate hospital admissions. The large number of small hospitals with very low bed occupancy and high staff to patient ratios raise serious concerns about fixed costs, ineffective utilization of limited resources, and quality assurance. Several hospitals exhibit an oversupply of identical departments that could be merged, thus allowing for substantial efficiency gains. Hospital managers have neither incentives nor authority to undertake changes to improve the efficiency and quality of their operation. Finalizing the country's hospital map is an important prerequisite to well guided future investments in the overall poor quality of Albania's hospital infrastructure. While accessibility concerns must be taken into consideration, there is a need to reduce the large number of small and underutilized hospitals. Multiple departments with the same profile across a relatively small catchment area or at times even within the same hospital should be consolidated. The decision to establish a regional hospital that would provide a substantial range of services in each regional prefecture also deserves further consideration, in view of Albania's limited resources to maintaining such a network. A smaller number of better equipped and maintained hospitals providing high quality services across more than one region would be a more effective use of limited resources. Management functions and accountability for the resource-mix should be unified at the facility level. Incentives must be set to managers to organize the delivery of health services in a cost-effective way.

94. **There is a need to substantially upgrade the quality of care.** Patient surveys point to serious quality issues, including dirtiness in hospitals; the lack of drugs, supplies and equipment, limited scope of services provision at PHC facilities, low skills of medical staff and the quality of services being conditional upon informal payments. The Government's Health Sector Strategy aims to improve the population's health status by improving the availability of high-quality health services. To achieve this ambitious goal, a considerable amount of work needs to be done in public PHC facilities and hospitals on standards of care, quality assurance, consumer protection, and skills upgrading of medical staff. Introduction of a quality improvement system will require a multi-pronged approach involving facilities managers, designated facilities staff, external surveyors and the health insurance institute as the agency which will purchase health services. It will also require raising awareness about the importance of continuous quality improvement among the medical profession as well as the wider population. Efforts at establishing and implementing standards will need to be complemented by skills upgrading of health care professionals.

95. **Albania's regulatory framework needs to be strengthened to properly harness the benefits of private sector health care providers.** As public providers will be granted increased autonomy and the private sector further develops, Albania will need to put in place a strong regulatory framework and set up mechanisms to ensure quality control. An effective system of safety and quality regulation and inspection is needed to ensure adequate standards of quality for equipment and facilities, and in particular to protect patients and staff from hazardous practice. As a first priority, the provider licensing system

should be upgraded and work on the establishment of quality standards completed. The MOH also needs to establish the regulatory framework and capacity to monitor private sector service provider activity.

96. **The health sector information base requires strengthening.** A better information base to appropriately monitor performance of the provider network is essential to support decisions on improved resource utilization. Information should be collected on utilization, provider activity, financial flows, staff allocations, and status of physical plant. This information could then be used to benchmark provider performance and make decisions on resource reallocation.

Annex 2.1 - Location of Care Seeking

This annex presents information about the location of care seeking for chronically ill in 2004 and for the entire population, unconditional on being ill in 2002 and 2004. It also provides a summary description of the LSMS household survey data set utilized in Chapter 2.

Table A2.1 - Location of Care Seeking for Persons Reporting Chronic Illness, 2004

	Prevalence of Chronic Illness	Type of provider during 4 weeks prior to interview			
		Private provider	Public clinic	Polyclinic Hosp OPat	Pharmacy
Female	25.92**	13.71	44.49	37.90	3.90
Male	19.04	12.79	38.05	45.83	3.33
Urban	22.68	9.07	45.26	40.76	4.91
Rural	22.71	16.58	39.69	40.96	2.77
Insured	33.61**	12.87	43.73	40.83	2.57
Not insured	11.96	15.02	36.47	41.02	7.49
Total	22.70	13.36	42.08	40.87	3.69

Level of significance: * p-value<0.05; ** p-value<0.01.
Source: LSMS panel survey 2004.

Table A2.2 - Type of Service, by Individual Characteristics, 2002 (N = 7,464)

Indicator	Public Ambulat	Nurse	Private	Dentist	Bought Drugs
<i>In Percent of all individuals</i>					
Male	12.03	3.21	1.14	16.29	14.16
Female	14.63**	4.0	1.8*	22.54**	15.23
Insured	18.13**	3.16	2.05*	19.84	15.85
Uninsured	10.85	3.86	1.18	19.34	14.71
Urban	12.67	2.08	1.74	21.62	12.39
Rural	13.74	4.43**	1.34	18.4	15.93*
Poorest	11.22	3.64	0.89	16.73	11.29
Q2	12.23	3.08	0.96	17.88	14.11
Q3	16.24	4.20	1.66	21.48	17.43
Q4	15.43	4.19	2.05	22.87	18.52
Better-off	14.63	3.10	3.50	23.97	16.56
Pearson Chi2	P<0.05		P<0.05	P<0.01	P<0.01
Total (%)	13.37	3.62	1.48	19.51	14.71

Level of significance: * p-value<0.05; ** p-value<0.01.
Source: LSMS Panel Surveys 2002.

Table A2.3 - Type of Outpatient Service, by Individual Characteristics, 2004 (N =5,519)

Indicator	Public Ambul.	Nurse	Private	Dentist	Hospital OPat
<i>In % of all individuals</i>					
Male	6.96	0.64	0.10	14.76	3.30
Female	11.84**	2.18**	2.05*	23.25**	4.90*
Insured	13.90**	2.24**	2.15**	18.70	5.92**
Uninsured	5.27	0.69	0.97	19.86	2.41
Urban	10.98	1.11	1.42	21.48	2.97
Rural	8.58	1.69	1.65	17.79	4.96*
Total (%)	9.55	1.46	1.56	19.28	4.15

Level of significance: * p-value<0.05; ** p-value<0.01. Note: response possibility is yes or no for each provider.
Source: LSMS Panel Surveys 2004.

Description of LSMS Data Sets Utilized

The LSMS 2002 is based on a probability sample of housing units (HUs) within the 16 strata of the sampling frame. It is divided in three regions: Coastal, Central, and Mountain Area. The urban areas of Tirana are considered as a separate region/stratum. The 2002 LSMS was conducted with a total of 3,599 households, and is representative at regional level (Mountain, Central, Coastal and Tirana) as well as for urban and rural domains.

The Albania Panel Surveys (APS) 2002 (wave 1) includes 1,741 panel households (891 urban, 850 rural) counting 7,475 longitudinal members including children aged under 15, that were drawn from the LSMS 2002 households. For the follow-up APS 2004 (wave 3) a single questionnaire on households has been used to collect information on 1,797 households counting 7,476 individuals, including children below 15 years. The APS 2004 sample includes 7,212 individuals who were already sampled in wave 1 (year 2002) or 2 (year 2003), and 264 new members. Analysis is carried out by comparing values for all individuals interviewed in the APS 2002 or 2004. The two APS are representative for urban and rural regions only and not on a regional level. The APS samples are designed to minimize the variability in households' selection probabilities. This section summarizes findings that are presented in the Albania Poverty Assessment based on the LSMS 2002 data,⁴¹ and uses APS 2002 and 2004 panel data to conduct additional analysis for comparison. The analysis is conducted in STATA8 using svydes commands. Findings from other studies are used to interpret findings.

The panel questionnaire used in 2004 did not collect any monetary and non-monetary consumption data to compute households' socio-economic status or test the robustness of proxy indicators. Using socio-economic status quintile variables that were identified in the LSMS 2002 to classify households interviewed in 2004 may cause implausible results as it assumes that households did not change their relative socio-economic ranking position since 2002. Therefore, the socio-economic analysis is limited to 2002 data.

⁴¹ World Bank: Albania Poverty Assessment. November 2003. Section 4; pp. 77-80.

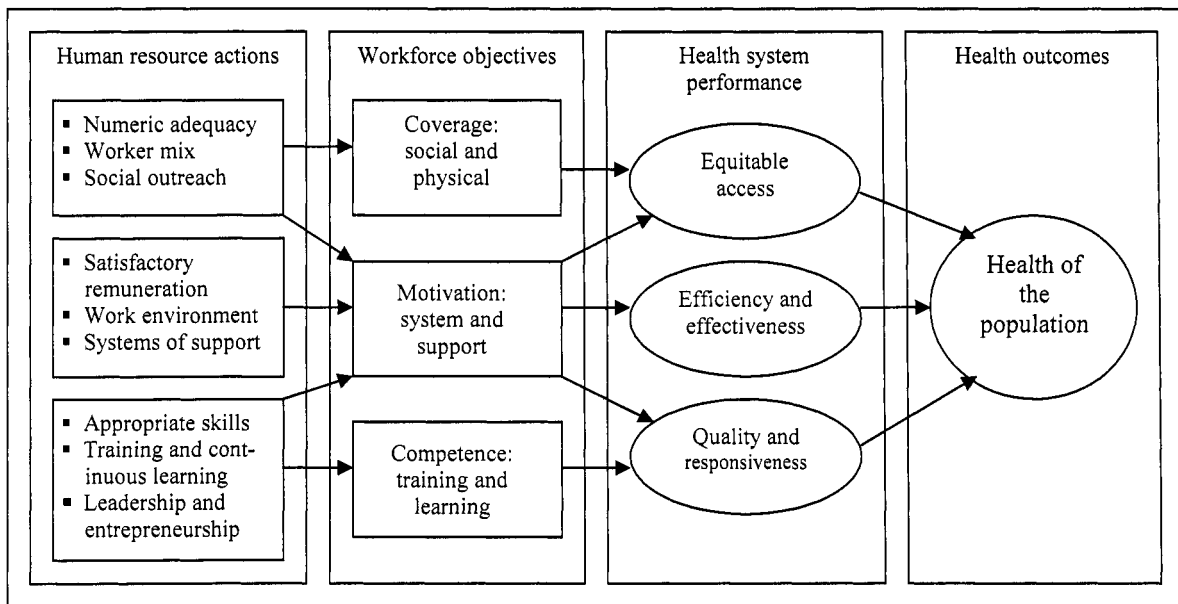
CHAPTER 3: HUMAN RESOURCES IN HEALTH

A. INTRODUCTION

Health care systems are complex, with interdependent external and internal subcomponents linked to each other, through either explicit rules or implicit understanding. An appreciation of human resource (HR) management issues is critical to understanding how these systems function, particularly because good HR management is often missing from the strategic management process in government organizations. Such an appreciation is even more critical where significant structural changes in the health sector are pursued.

97. **Research has shown that the number, mix, skills, remuneration, and support systems for health workers have a direct and often significant impact on health system performance and, ultimately, the achievement of health outcomes.**⁴² A conceptual framework presented in a recent Lancet article will be used as the framework for analyzing health human resources in Albania (Figure 3.1).⁴³ It highlights the impact of HR actions on the overall performance management process.

Figure 3.1 - Framework to Analyze Health Sector Human Resource Issues



98. This chapter will focus on each of the human resource workforce objectives (coverage, motivation, and competence), examining the related human resource actions and the health system performance issues related to them. Finally, the chapter will provide some overall conclusions and recommendations.

⁴² See Chen, L., et al., "Human Resources for Health: Overcoming the Crisis," *Lancet*, Vol. 364, November 27, 2004, pp. 1984-1990.

⁴³ *Ibid*, p. 1987.

B. WORKFORCE COVERAGE

99. **Although the share of health sector employment in total paid employment has risen over the last 5 years, it still constitutes a relatively modest 2.9 percent of total paid employment** (Table 3.1). Overall, health employment increased by about 8 percent between 1997 and 2003, while total paid employment decreased by about 16 percent over the same period of time.

Table 3.1 - Distribution of Employed by Nature of Employment, 1997-2003 (%)

	1997	1998	1999	2000	2001	2002	2003
Health Care	2.3	2.6	2.4	2.2	2.9	2.9	2.9
Education	4.4	4.5	4.5	4.4	5.5	5.4	5.3
Agriculture, Forestry, Fishery	69.6	70.8	72.1	71.8	57.7	57.8	58.2
Construction	1.4	1.0	1.0	1.2	6.1	6.1	6.0
Other Industry	6.5	6.3	6.2	4.6	6.8	6.8	6.5
Transport, Trade, Communications	6.7	5.0	5.7	7.0	10.8	10.8	10.8
All Other	9.1	9.9	8.0	8.8	10.2	10.2	10.3

Source: INSTAT

100. **Since the mid-1990s, the number of doctors in Albania has posted a modest decline, while the number of nurses has declined quite dramatically.** WHO HFA data suggest that the number of doctors dropped by about 4 percent (178 doctors) between 1996 and 2002, while the number of nurses dropped by about one-fifth (2,800 nurses) from the 1996 levels (Table 3.2).⁴⁴ This has resulted in a concomitant decrease in the ratio of nurses to physicians, to 2.78:1 by 2002. For nurses, the largest decline appears to have taken place after the 1997 unrest, although the decline appears to continue with a significant number of Albanian nurses leaving the country and a drop in nursing students.

Table 3.2 - Number of Physicians and Nurses, 1996-2002

	1996	1997	1998	1999	2000	2001	2002
Doctors	4,278	4,304	4,325	4,325	4,325	4,100	4,100
Index, 96=100	100	101	101	101	101	96	96
Nurses	14,284	14,284	12,730	12,730	12,570	11,993	11,470
Index, 96=100	100	100	89	89	88	84	80
Ratio	3.34	3.32	2.94	2.94	2.91	2.93	2.78

Source: Database "Health For All", www.who.dk/hfadb

101. **Albania's physician and nurse densities are commensurate with those of other lower middle income countries, but are among the lowest in the European Region.**⁴⁵ Although the ratio of nurses to physicians in Albania is relatively high compared to other countries, this is the result of a relatively low level of physicians per capita, rather than an over-abundance of nurses. With 3.7 nurses per 1,000 people and 1.3 doctors per 1,000 people, Albania ranks fourth lowest in the region after Bulgaria, Turkey and Andorra, in terms of nursing coverage and lowest in terms of physician coverage (see Annex 3.1). It is,

⁴⁴ WHO HFA human resource data for Albania differ somewhat from those provided by the MOH, although the WHO data also come from the MOH. This is an indication of the overall weak state of the health sector information base in general and of the human resource database in particular.

⁴⁵ WHO, 2005.

however, noteworthy that Albania does rank better with respect to GP coverage, a reflection of the Government's efforts to improve access to primary care. While Albania is thus less well endowed with medical staff than other countries in the region, the low utilization rates and ensuing low productivity of health care professionals in public facilities suggest an oversupply rather than a shortage of medical staff for the level of Albanian's health care demand.

Table 3.3 - Physicians and Nurses per 100,000 Population (2003 or latest year)

	Albania	Bulgaria	Croatia	Romania	Turkey	Europe
Physicians	132.9	359.5	243.6	195.7	136.7	358.0
Index, AL=100	100	270	183	147	103	269
Nurses	369.7	379.0	503.7	399.4	244.0	818.0
Index, AL=100	100	103	136	108	66	221
Ratio	2.78	1.05	2.07	2.04	1.78	2.28

Source: Database "Health For All", www.who.dk/hfadb.

102. In contrast to the numbers of physicians and nurses, Albania is relatively better endowed with dentists and pharmacists (Table 3.4), both professions have been largely privatized. Overall, Albania's relatively low medical personnel density compared to the European average is a reflection of the relatively low level of health system development and is not out of line with the level of other lower middle-income countries.

Table 3.4 - Other Medical Staff per 100,000 (2003 or latest year)

	Albania	Bulgaria	Croatia	Romania	Turkey	Europe
Dentists	41.4	82.8	69.5	22.4	24.6	65.8
Index, AL=100	100	200	168	54	59	159
Pharmacists	39.2	12.5	52.9	6.3	32.1	81.7
Index, AL=100	100	32	135	16	82	208

Source: Database "Health For All", www.who.dk/hfadb.

103. **The physician workforce is overspecialized, but the skill level of many specialists is low compared to their colleagues in Europe.** As shown in Table 3.5, about 40 percent of all physicians in Albania are family physicians, and this ratio has been steady, rising only slightly over the last 5 years. Obstetricians/gynecologists are the next largest group, but are just 6 percent of the total, followed by surgeons and pediatricians. The relatively large number of physicians not in the 17 main specialties (750 in 2003 or 20 percent of the total) indicates a high degree of sub-specialization in Albania, which may not be appropriate given the overall state of development of the health system. On the other hand, the relatively small numbers in particular specialties such as psychiatry, urology and oncology means that these specialists are particularly vulnerable to even small changes, and therefore specific attention needs to be paid to planning for and retaining these staff.

Table 3.5 - Number of Physicians by Basic Specialities, 1999-2003

	1999	2000	2001	2002	2003
Family Physicians	1,557	1,557	1,578	1,586	1,590
Obstetricians-gynecologists	229	235	227	223	223
Surgeons	201	201	195	199	198
Pediatricians	139	139	145	154	154
Anesthesiologists	135	130	128	123	123
Laboratory specialists, pathologists	115	115	120	98	100
Cardiologists	120	116	110	115	89
Radiologists	81	81	81	88	88
Epidemiologists /communicable disease	79	79	79	68	68
Ophthalmologists	54	54	54	57	57
Otolaryngologists	48	48	48	54	54
Psychiatrists	33	35	40	41	46
Neurologists	55	55	55	43	43
Dermatologists / venerologists, allergists	48	48	48	41	41
Endocrinologists	43	43	43	36	36
Urologists	18	18	18	20	20
Oncologists	15	15	15	17	19
All other	684	660	634	693	750

Source: Ministry of Health.

104. **Nurses, as a group, are highly homogeneous, with virtually all nurses working as medical nurses, midwives, or doctors assistants.** This situation has been remarkably stable over the last 5 years (Table 3.6). There is no indication of the number of nurses engaged in particular specialty areas, such as public health nursing, primary care, head nurses, and critical care specialties. Recording and planning for these types of staff could become more important as the health system evolves.

Table 3.6 - Number of Nurses by Basic Specialities, 1999-2003

	1999	2000	2001	2002	2003
Medical nurses	8,640	8,650	8,650	8,654	8,721
Midwives	2,546	2,450	2,530	2,480	2,415
Doctors' assistants	1,535	1,540	1,560	1,578	1,585
Doctors' assistants – laboratory assistants	361	378	392	384	411
Other	450	360	320	392	387

Source: Ministry of Health.

105. **There are marked regional imbalances in medical personnel coverage. Regional variations are highest for specialists and pharmacists, and lowest, though still considerable, for primary care physicians** (Table 3.7 and Figure 3.2). The relatively lower variation in general practitioners may partly be the result of a concerted Government effort to motivate general practitioners in rural areas through higher payments. Although Tirana is quite far ahead of other regions in the numbers of specialists and pharmacists per capita, it is not the highest in all categories of health personnel, including general practitioners, nurses and dentists. Fier is the most sparsely covered of the 12 regions, with only 389

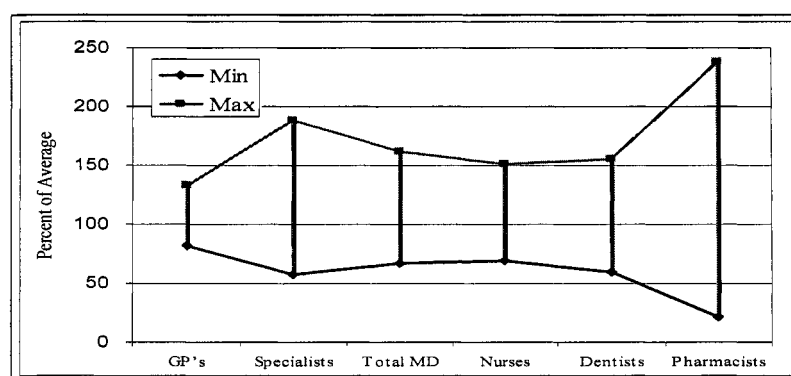
medical staff per 100,000 population compared to 569 for the country as a whole. It is interesting to note that the region has a somewhat better coverage of GPs (85 percent of the national average), ahead of Elbasan and Lezhe, but it has considerably fewer specialists, nurses/midwives, and dentists than other regions. Steps will need to be taken to address these variations if equitable access to services is to be assured throughout Albania.

Table 3.7 - Medical Staff per 100,000 Population by Region, 2002

Area	Region	Physicians			Nurses/ Midwives	Dentists	Pharmacists
		GPs	Specialists	Total			
Central	Albania	50.73	90.18	140.91	414.76	9.68	3.71
	Berat	47.66	67.87	115.53	439.33	7.77	2.59
	Elbasan	41.35	55.69	97.04	377.13	7.72	1.65
	Gjirokaster	67.36	115.22	182.57	627.49	15.07	5.32
	Korce	44.89	80.80	125.68	588.91	6.28	4.49
Coastal	Shkoder	44.84	68.23	113.07	435.13	8.19	0.78
	Durres	55.88	75.86	131.74	320.99	11.42	2.04
	Fier	43.13	51.76	94.89	286.24	5.75	1.83
	Lezhe	42.72	56.54	99.26	406.45	7.54	2.51
Mountain	Vlore	60.11	100.01	160.12	462.74	10.88	2.59
	Diber	43.72	62.15	105.87	498.28	6.32	3.16
	Kukes	60.34	89.75	150.09	455.16	13.20	3.77
Tirana	Tirana	57.70	170.10	227.80	411.27	13.21	8.86

Source: Ministry of Health.

Figure 3.2 - Regional Variation in Public Sector Staffing



Source: Ministry of Health.

C. MOTIVATION

106. **The health care workforce in Albania is quite young**, with an average age of less than 45, and with definite patterns with respect to gender (Tables 3.8a and 3.8b, and Figure 3.3). Nurses, midwives, pharmacists, and dentists are overwhelmingly female, while specialist physicians are overwhelmingly male. General practice appears to be the most balanced of the health professions in terms of gender, although the younger cohort of GPs has a higher proportion of males than females, unlike the older cohorts, which are predominantly female. As a group, physicians are much older on average than other

professions, with 25 percent of all GPs and 26.6 percent of all specialists being 50 years of age or older. This compares with 19 percent for pharmacists, 15 percent for dentists, and 17 percent for nurses and midwives.

Table 3.8a - Distribution of Medical Staff by Age – Male, 2003

	<30	30-40	40-50	50-55	55-60	60-65	Total
Physicians							
Specialists	110	380	450	250	98	45	1,333
GPs	55	345	275	150	35	10	860
Dentists	45	180	245	75	35	-	580
Pharmacists	28	75	102	55	18	-	278
Nurses	65	890	920	54	20	-	1,949

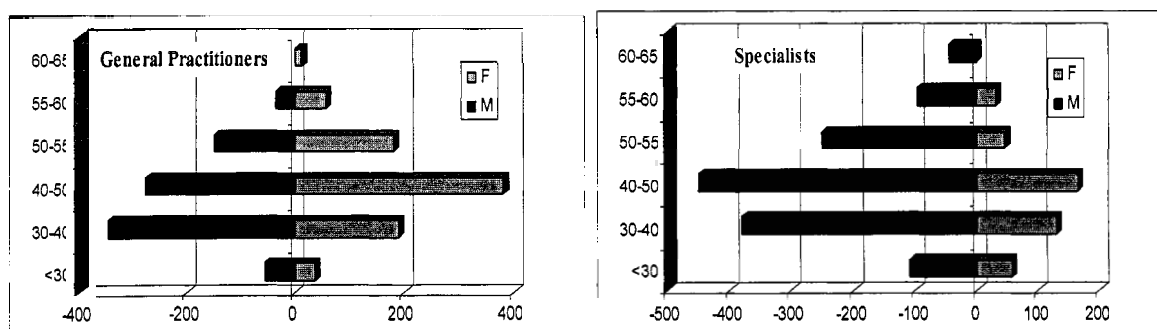
Table 3.8b - Distribution of Medical Staff by Age – Female, 2003

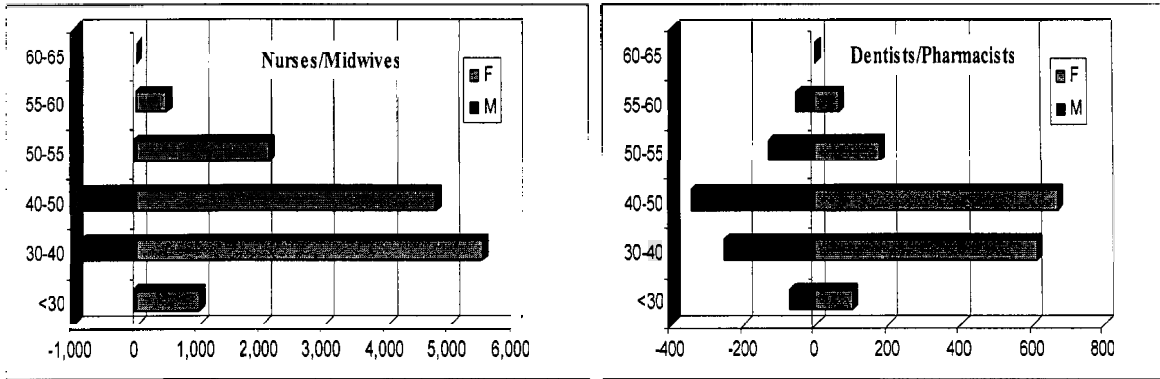
	<30	30-40	40-50	50-55	55-60	60-65	Total
Physicians							
Specialists	55	130	165	45	30	-	425
GPs	35	190	380	180	55	12	852
Dentists	40	350	250	65	25	-	730
Pharmacists	60	260	420	110	40	-	890
Nurses	780	4,250	3,865	1,860	354	-	11,109
Midwives	215	1,245	895	250	120	-	2,725

Source: Ministry of Health.

107. **To address impending retirements from the workforce over the next decade, planning needs to start now.** About 900 GPs and specialists and almost 2,700 nurses and midwives are likely to retire over the next decade. Planning for adequate nursing replacement is of particular importance in light of the fact that there is a relatively smaller age cohort in the younger age group (only 1,060 nurses and midwives under 30) and that Albania continues to witness significant out-migration of nurses. The current nursing school intake is unlikely to be sufficient to maintain the nursing workforce at its current levels (see Box 3.1, below). However, planning also needs to take into consideration the substantial room for productivity increase with existing or even lower medical staff numbers.

Figure 3.3 - Population Pyramids by Profession





Source: Ministry of Health

Table 3.9 - Number Employed in Location by Year, 1999-2003

Total Staff	1999	2000	2001	2002	2003
Hospitals	16,621	16,811	16,376	16,334	16,220
HC/HP	8,997	9,070	9,152	9,174	9,193
Polyclinics	2,025	2,007	1,990	1,982	1,985
Public Health	1,034	1,012	975	997	997
Total	28,677	28,900	28,493	28,487	28,395
Index, 1999=100					
Hospitals	100.0	101.1	98.5	98.3	97.6
HC/HP	100.0	100.8	101.7	102.0	102.2
Polyclinics	100.0	99.1	98.3	97.9	98.0
Public Health	100.0	97.9	94.3	96.4	96.4
Total	100.0	100.8	99.4	99.3	99.0
Percent of Total Staffing					
Hospitals	58	58	57	57	57
HC/HP	31	31	32	32	32
Polyclinics	7	7	7	7	7
Public Health	4	4	3	3	4
Total	100	100	100	100	100

Source: Ministry of Health.

108. **The distribution of health care personnel by facility level points to a continued over-emphasis on the hospital sector.** The MOH currently estimates that just over 28,000 persons are employed in the publicly financed health sector in Albania. No accurate numbers for the private sector employment of health care professionals are available.⁴⁶ Staffing patterns have not shifted significantly in

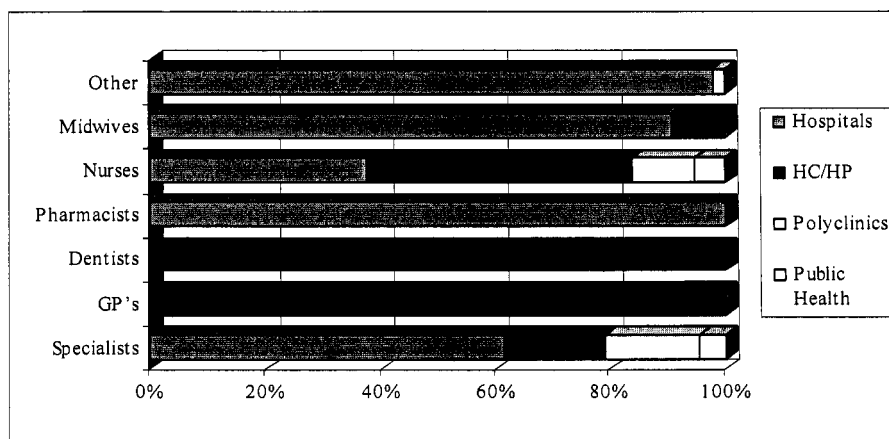
⁴⁶ The MOH figures from 1999 suggest that about 11 percent of the professional health sector workforce was officially engaged in the private sector at that time, with the majority of these being dentists and pharmacists. More recent data are not available according to MOH and INSTAT. However, anecdotal evidence suggests that a

the past 5 years (Table 3.9), with only a slight increase in the number of staff employed health centers and health posts, a 2.4 percent decrease in hospital staffing, a 3.6 percent decrease in public health staffs, and a 2.0 percent decrease in polyclinic staffing. As a percentage of total staffing, health clinics and health posts have increased by 1 percentage point to just under one-third, while hospitals have declined by the same amount to 57 percent, and other sectors have stayed the same.

109. Nurses make up the largest professional group, followed by non-medical staff, midwives, specialists, and general practitioners. Hospitals employ virtually all of the non-medical staff, pharmacists and midwives, while GPs and dentists are mostly found in health centers and health posts (Figure 3.4). These figures do not include dentists and pharmacists in private practice. Specialists and nurses are spread throughout the health system, although 60 percent of specialists work in hospitals, while just under half (47 percent) of nurses work in primary care.

110. **Health sector wages have tended to lag behind other parts of the public sector** (Table 3.10). Only construction and agriculture have lower average wages, and the health sector is significantly behind the education sector, which is often used as a benchmark sector in other countries. In the medium term, health sector salaries will need to be revisited if Albania wants to avert a considerable brain drain of medical staff abroad and start curbing informal payments.

Figure 3.4 - Distribution of Health Professions by Location, 2003



Source: Ministry of Health.

significant number of health care professionals engaged in the public sector also moonlight in private practice, which makes it likely that the share of those at least partially engaged in the private sector is significantly above 11 percent.

Table 3.10 - Average Monthly Public Sector Wages, 2000-2003

	Average Salary in Lek				Percent of Health Level			
	2000	2001	2002	2003	2000	2001	2002	2003
Total	14,963	17,218	19,659	21,325	116	122	129	119
Health	12,847	14,148	15,280	17,985	100	100	100	100
Education	14,760	17,358	18,263	21,263	115	123	120	118
Agriculture, Forestry, Fishing	11,933	14,897	16,123	17,537	93	105	106	98
Industry	13,899	15,912	17,082	20,727	108	112	112	115
Construction	12,392	13,961	15,856	16,670	96	99	104	93
Trade	11,588	14,204	15,677	19,204	90	100	103	107

Source: INSTAT, Albania in Figures, 2004.

111. **Hospital sector wages have grown faster than other health sector wages over the past few years.** The overall increase in sectoral wages over the past few years has been uneven across locations of care, with hospital sector wages growing the most rapidly (Figure 3.5). Polyclinics and primary health care centers have the lowest growth rates, although these rates are still around 10 percent per year. Salaries vary little across type of facility, location, and staff, except for physicians and administrative staff (Table 3.11). Within the administrative staff group there is considerable variation, depending on the managerial or administrative position.

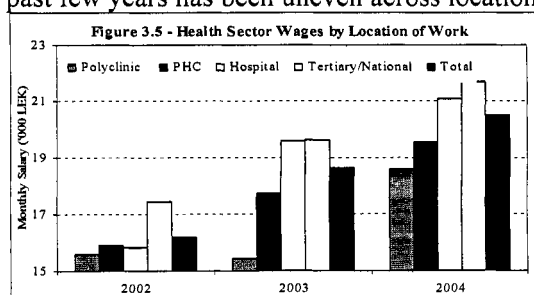


Table 3.11 - Average Salaries by Type of Institution, Health Sector (x 1,000 Lek)

Provider Type	Physicians	Nurses	Low medical personnel	Admin. staff	Technical	Support
All Providers						
Tirana	21.8	16.7	16.6	32.6	13.4	12.9
Outside Tirana	21.0	16.3	16.0	26.3	13.4	12.9
University hospitals	23.7	17.5	17.9	44.0	13.4	12.9
Other hospital	21.7	16.8	16.8	23.9	13.4	12.9
Polyclinics	20.0	15.9	15.0	28.6	13.4	12.9
Health center *	42.8	15.9	15.0	n/a	n/a	12.9
Health post *	42.8	15.9	15.0	n/a	n/a	12.9
Other MOH	26.1	16.2	15.6	31.5	18.5	12.9
of which:						
IPH	33.7		15.2	27.7	13.4	12.9
National Drug Center			16.2	30.1	13.4	12.9
Gov. Medical Service						
Cent.	21.7	16.2	14.5	28.1	13.4	12.9
National Blood Center	22.8	16.2	16.6	24.6	13.4	12.9
Biomedical workshop				22.7	13.4	12.9

Source: Ministry of Health, * physician salaries for health centers and health posts are from HII.

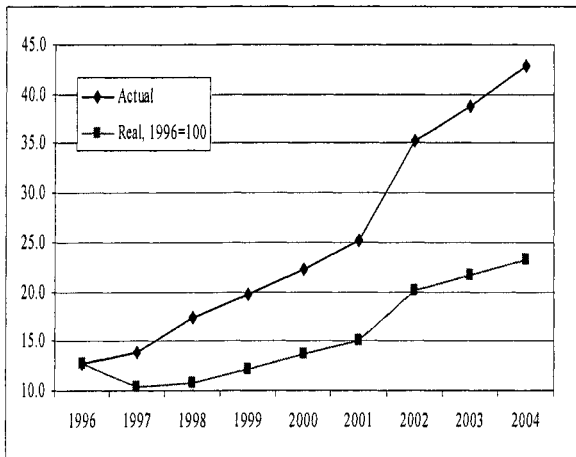
112. **Urban and rural salary structures indicate that only physicians have explicit recognition of regional differences within their salary structures** and reflect the Government's policy of motivating general practitioners to remain in rural areas (Table 3.12). In an effort to motivate GPs to serve in more remote areas, GP remuneration has been structured to allow for significant location premiums, in addition to capitation supplements to a base salary. The various factors can lead to substantial differences in GP payments. For example, the minimum salary for a young physician with a normal patient load (1,700) in a non-remote commune would be about 32,000 lek per month, while the same physician would earn about 21,000 in a central municipality and 61,000 in a remote mountainous commune. These policies appear to be quite effective and are consistent with an increasing emphasis on the GP as the key provider of care. They are likely to explain the relatively narrower range of distribution of GPs compared to other health professions. Figure 3.6 shows that over the last 9 years, GP salaries have more than tripled in nominal terms and almost doubled in real terms. Moreover, as seen in Figure 3.7, higher salaries are channeled to areas which are relatively underserved. In addition to the base salary, different professions have additional adjustments that could greatly increase their overall earnings. For example, nurses are able to earn increments for service (2 percent per year), as well as for shift work, on call, and specific functions such as head nurse, intensive care nurse, and other specializations. Obviously, there are greater opportunities in urban areas to access these additional payments.

Table 3.12 - Urban and Rural Salary Structures

	Minimum salary	Maximum salary	Average salary
GP urban area	25	42	33
GP rural area	35	60	47
Premium for rural	40.0%	42.9%	42.4%
Specialist urban/rural	19.3	20.8	20
Nurse urban/rural	14.5	17.3	15.9

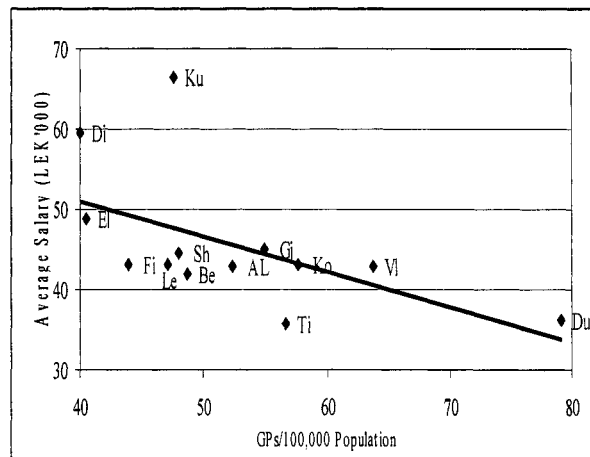
Source: Ministry of Health.

Figure 3.6 - Monthly Salaries of GPs ('000 lek)



Source: Ministry of Health.

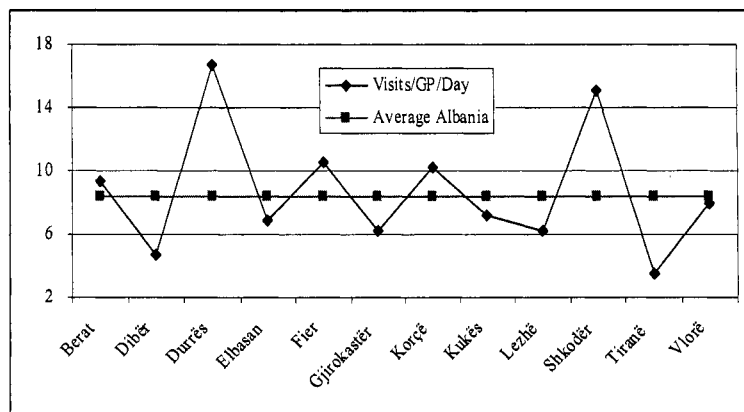
Figure 3.7 - GP Salaries versus per Capita Distribution



Source: Ministry of Health.

113. **Physician productivity is low and varies significantly across regions (Figure 3.8).** Albania has one of the lowest outpatient contact rates per capita in the region (see Chapter 2) and productivity of outpatient physicians is extremely low. On average, a GP in Albania sees only about eight patients per day and this drops to below four patients per day in Tirana and less than five in Diber, while in Durres and Shkoder, a GP sees on average over 15 patients per day. Tirana is an interesting case in point, where polyclinics rather than health centers or health posts provide the bulk of primary care services. This indicates that although GPs are available and well paid, there is a major issue in encouraging the population to make use of GP services. This indicates substantial room for increased productivity in the primary care sector. Unless productivity is increased, even the relatively low density of physicians is too high and results in ineffectively utilized resources.

Figure 3.8 - Visits per Day per General Practitioner by Region



Source: Ministry of Health.

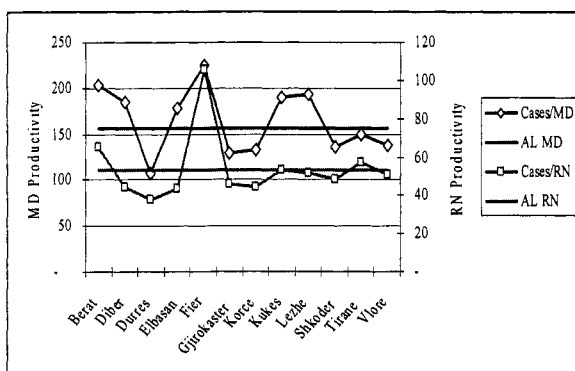
114. **Hospital staff productivity in Albania lags behind that in most other countries and varies considerably across regions.** Hospital staff productivity is greatly affected by the size of the hospital infrastructure, but regardless of the measure used, staff productivity in Albanian hospitals lags behind that in most other countries (Table 3.13) and shows considerable regional variation (Figures 3.9a and 3.9b). The differences are most pronounced in the data on hospital days, which reflect the lower occupancy rates and average length of stay in Albania. Considerable inter-facility and regional variations also persist. These points to an overall need to better match human resources to actual hospital activity systemwide, as well as to the regional and facility level. In addition to the obvious cost implications of having excessive staffing levels, low productivity also has an impact on employee morale and motivation, since most professionals take pride in providing effective high quality service. Underutilization of such talent is a great de-motivator and also drives the demand for informal payments, since the available funding is spread over too many staff.

Table 3.13 - Hospital Productivity (2003 or latest year)

	Albania	Bulgaria	Croatia	Romania	Turkey
Beds/MD	3.84	3.89	4.21	6.41	3.27
Index, AL=100	100	101	109	167	85
Beds/RN	1.93	2.50	1.74	2.60	2.36
Index, AL=100	100	130	90	135	122
Days/MD	723	956	1,337	1,948	601
Index, AL=100	100	132	185	269	83
Days/RN	363	614	554	790	434
Index, AL=100	100	169	153	218	120
Cases/MD	110	109	122	243	104
Index, AL=100	100	99	111	222	95
Cases/RN	55	70	50	99	75
Index, AL=100	100	127	92	180	136

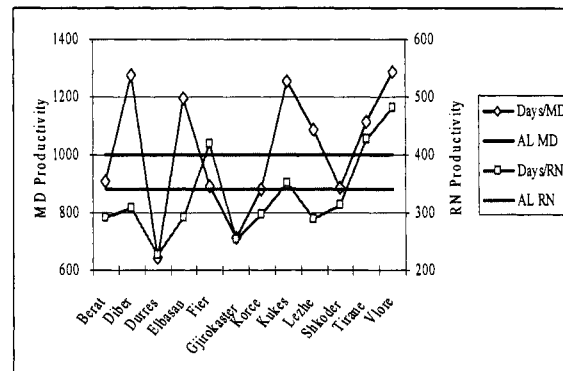
Source: Database "Health For All", www.who.dk/hfadb.

Figure 3.9a - Hospital Cases per Physician or Nurse



Source: Ministry of Health.

Figure 3.9b - Hospital Days per Physician or Nurse

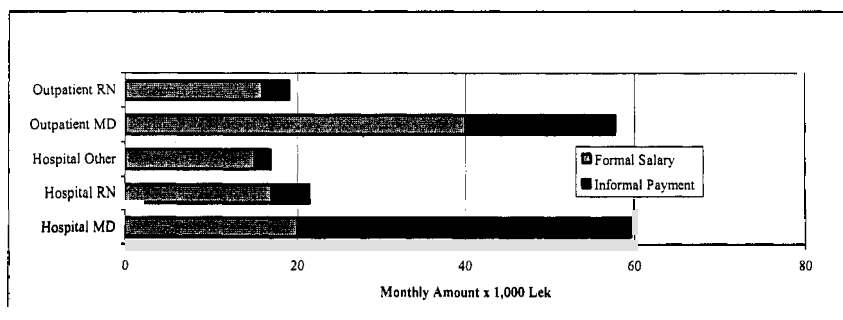


115. **Income from informal payments is substantial, particularly for hospital staff.** While no official data are available on informal earnings, household surveys provide some indication of the extent of these practices (see Chapter 5). Extrapolation of information from these surveys can provide an indication of the order of magnitude of such income. Figure 3.10⁴⁷ shows that such payments can have a significant effect on the incomes of physicians, especially at the hospital level, where informal payments are widespread and substantial. The data suggest that informal payments for hospital physicians may amount to at least twice the amount of officially received wages, though there clearly will be significant variations across physician types, with certain surgical specialists earning considerably more informally than others. For outpatient physicians, the impact may be almost 50 percent. As discussed in Chapter 5,

⁴⁷ Numbers in Figure 3.10 were derived by multiplying the average informal payment per encounter reported in the LSMS by the likelihood of having paid and overall monthly contact rates. Figures so derived were then apportioned to physicians (60 percent), nurses (30 percent) and other staff (10 percent). Figures should be used with caution and are presented here only for indicative purposes.

any efforts to root out informal payments will need to take the relative high income share of such payments into consideration and allow for performance-based correction of at least part of this income.

Figure 3.10 - Formal and Informal Payments



Source: Ministry of Health and LSMS 2002.

116. **Motivation of Albanian medical personnel is further affected by the absence of performance management, career planning, and merit based recruitment systems.** It is clear that such issues will need to be addressed if productivity and optimal use of the available human resources are going to be addressed. A recent review of hospital management at Durres and Tirana Hospital found that:

*Human resources are hampered by the conditions imposed upon the hospital for the number, type, and salary levels of the workers. Job descriptions ... are non-existent, and job performance is not evaluated. Consequently, no one is ever dismissed or disciplined, which creates a cynical attitude and fosters malingering and truancy. While it is difficult to document, it is likely ...given these conditions that job placement is often based upon personal connections and favoritism, rather than qualifications.*⁴⁸

D. COMPETENCE

117. As with other areas of health human resources, the issue of competence has many dimensions, encompassing initial medical training, post-graduate training, continuing medical education, and ongoing quality assurance and clinical improvement programs. As in most developing countries, these systems are largely undeveloped in Albania, although the Government recognizes this and has made quality improvement a key theme of its Long-term Health Sector Strategy.

118. **An apparent shift to a higher proportion of female involvement in non-nursing professions could have a major impact on the working patterns of these professionals, with significant human resource planning implications.** Enrollment in medical education made up 11.4 percent of total university enrollment in 2001, and medical school graduates comprised 10.7 percent of those graduated. The proportion of women in the first year enrollment was about 70 percent for medicine and 80 percent overall for nursing, although some nursing schools approached 90 percent women. This compares to a current distribution of 86 percent female in nursing and 50 percent in other medical professions.

⁴⁸ Metis Advisory Group, *Hospital Sector Management, Tirana University Medical Center "Mother Theresa," Final Report*, to the Ministry of Health, September, 2004.

Table 3.14 - Medical Schools in Albania, 2001-2003

Profession	Institution	First Year Enrollment			Graduates		
		2001	2002	2003	2001	2002	2003
Physicians	U. of Tirana	198	166	285	172	193	146
Dentists	U. of Tirana	78	71	105	67	72	61
Pharmacists	U. of Tirana	50	48	76	32	36	23
Nurses/midwives	Total	520	683	830	245	286	318
	Vlora	104	146	180	66	60	67
	Tirana	140	146	231	108	115	133
	Elbasan	72	90	99			
	Korce	108	120	119	56	80	85
	Shkoder	53	111	113			
	Gjirokaster	43	70	88	15	31	33

Source: INSTAT, Education Statistics, Ministry of Education and Science.

119. **Nurses training figures show a considerable gap between enrollment and number of graduates in succeeding years, indicating a high level of dropping out** (Table 3.14). Table 3.15, taken from the WHO Health For All database, indicates that the number of graduates from medical schools has been declining quite dramatically for physicians (almost 50 percent since 1997), has been increasing for nurses, and has been quite erratic for dentists and pharmacists. These numbers differ considerably from those from the Ministry of Education, which may also require some attention.⁴⁹ There is clearly a need for the MOH to compile these data on a regular basis for its own planning purposes.

Table 3.15 - Total Graduates from Medical schools by Year, 1997-2003

	1997	1998	1999	2000	2001	2002	2003
Doctors	336	293	153	150	144	172	188
Nurses		117	140	164	188	245	
Dentists	57	44	27	32	68	67	77
Pharmacists	39	30	19	32	12	32	36

Source: Database "Health For All", www.who.dk/hfadb

120. **Compared to the existing workforce, the number of graduates is exceedingly low for nurses and pharmacists, but has risen recently for physicians and for dentists** (Table 3.16). It is not clear whether the increased numbers of graduates in these programs reflects a permanent increase or a temporary spike in activity. Compared to neighboring countries, Albania produces relatively higher numbers of physician and dentist graduates as a percent of the current workforce but relatively fewer nurses and pharmacists (Figure 3.1)

⁴⁹ The data for nurses differ somewhat from the WHO data. This may be due to midwives being included in one total and not in the other or to incomplete reporting from some institutions.

Table 3.16 - Graduates per 100 Practicing Professionals by Year, 1997-2003

	1997	1998	1999	2000	2001	2002	2003
Doctors	7.8	6.8	3.5	3.5	3.5	4.2	4.6
Nurses	0.0	0.9	1.1	1.3	1.6	2.1	0.0
Dentists	4.2	3.2	1.9	2.5	5.4	5.2	6.0
Pharmacists	3.1	2.4	1.5	2.6	1.0	2.6	2.9

Source: Database "Health For All", www.who.dk/hfadb

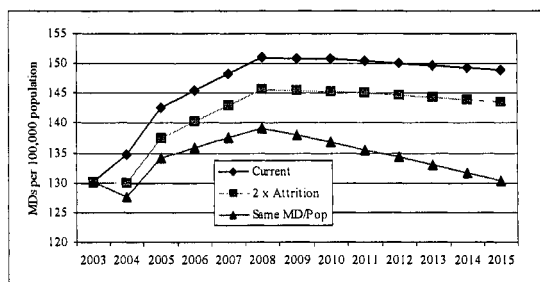
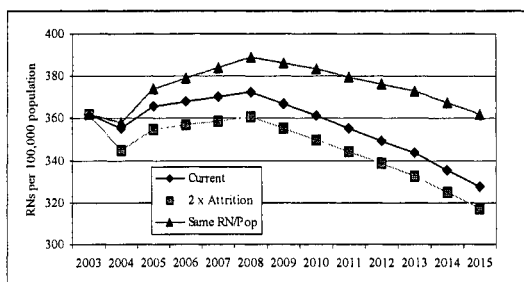
Box 3.1 - The Dynamics of Health Human Resources

To estimate the impact of the current age structure, attrition rates, and graduation levels on the available health human resources in Albania, "stock and flow" models of the physician and nursing workforces were constructed using the available data. These models were then used to construct three scenarios using different levels of medical

Scenario	Current	2x Attrition	Same/capita
Physicians			
Graduates	188	188	150
Attrition	3.6%	7.2%	3.6%
Nurses			
Graduates	245	245	340
Attrition	3.0%	6.0%	3.0%

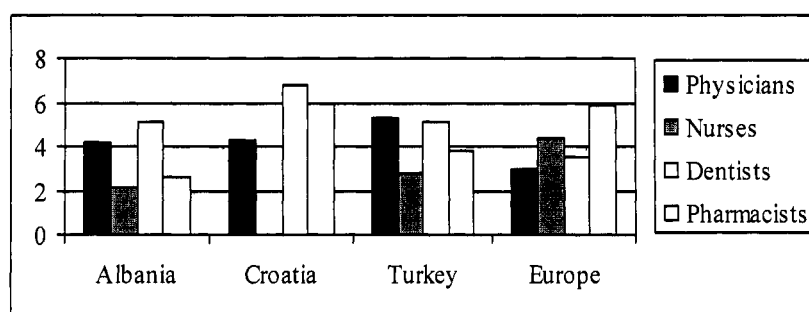
school graduates and attrition rates, as follows: (i) continuation of present levels for both graduates and attrition, (ii) higher attrition due to out-migration or movement of staff into other sectors, and (iii) adjustment of levels of graduates to achieve the same number of physicians and nurses per capita as in 2003. Of course, many other scenarios are possible to fit with the Government's priorities for HRH and much needs to be done to refine both the input data and model variables, but these models are designed to illustrate the potential value of using this approach. The parameters are shown in the above

table. The two graphs below illustrate the results.



There are significantly different results for the two professions, reflecting different age structures and current graduate production. The first graph shows the model results relative to physicians, with the current level of production leading to significant increases in the supply of physicians, even if attrition doubles from the current level. It is only when physicians in the 50-55 year age cohort start reaching retirement age that the supply per capita starts to decline. The model indicates that a medical school output of 150 graduates per year – compared to the current level of 188 – would be needed to achieve the same per capita supply as in 2003. However, given the relatively low level of physicians per capita relative to neighboring countries, some increase in physician supply can probably be tolerated as long as these physicians are used productively. The situation with respect to nurses is quite different, with the current (2002) level of graduates leading to a 10 percent decline in per capita supply between 2003 and 2015. Rising attrition would exacerbate this problem. A 39 percent increase – to 340 per year – is needed in nursing school graduates just to maintain the current level of per capita supply. Given the earlier discussion on the overall level of nursing supply, further reductions are probably not appropriate. However, as in physician services, productivity issues need to be addressed.

Figure 3.11 - Graduates per 100 Active Professionals, 2002



Source: Database "Health For All", www.who.dk/hfad

121. In an attempt to quantify the potential impact of workforce dynamics on the needs for medical education, a model of health human resources was constructed, and is described in Box 3.1. It shows that the current level of production of nurses is likely to lead to a significant decline in available nurses, while the level of production of physicians may increase slightly. Even the relatively simple results from this model demonstrate the value and the necessity of formal health human resource planning processes in Albania.

E. MAJOR ISSUES IN MEDICAL EDUCATION

122. **At the present time, as in many countries, the responsibility for medical education lies with the Ministry of Education, yet the responsibility for licensing, employing, and planning for the health care workforce lies with the MOH.** In an effort to address this, a steering committee has been set up with these ministries, the HII and other stakeholders to address education issues. However, this committee can only make recommendations, since the final decisions on the numbers of students are subject to the available budget in the Ministry of Education (MOE). This can result in discrepancies between the clinical needs and the supply of trained professionals. It is most acutely felt in the area of post-graduate training, since the training of specialists takes such a long time. Another issue is student selection of their post-graduate specialty, which is exacerbated by having an excess of positions relative to the available graduates. Table 3.17 shows the current enrollment by year and especially shows some potentially significant issues, including large year-to-year variations (e.g., gastroenterology, ophthalmology) and a dwindling "pipeline" (e.g., orthopedics, endocrinology). However, in the absence of detailed information on the current physician stock and expected retirements, it is not clear how serious these issues are. It does reinforce the need to perform human resources planning at this level of aggregation.

123. **Current legislation places limitations on non-physician medical staff's ability to work independently and therefore limits staff substitutions.** Possibilities for staff substitutions are limited both within and outside of the publicly financed system and may prevent more effective use of staff, such as the increasing use of nurse practitioners to substitute for physicians. A review of staffing use at Durres and Tirana University Hospital found that there is substantial room to substitute nursing time for physician time and clerical staff for work which nurses are now performing. The issue of substitution is one that is currently receiving a considerable attention in Europe, as the countries are facing significant human resources issues over coming years as the "baby boomers" start to retire. Table 3.18 highlights

some of the approaches currently being considered to address this issue in Europe.⁵⁰ It also highlights some of the new roles and skills that will be needed in Albanian hospitals as it aspires to achieve European standard, and thus presents yet another human resources training challenge.

Table 3.17 - Current Post-Graduate Enrollment by Specialty and Year

SPECIALTY	Year 1	Year 2	Year 3	Year 4	Total
Pediatrics	11	15	8	9	43
Anesthesiology-Intensive Care	10	13	5	8	36
General practitioners	14	17	3	0	34
Obstetrics-Gynecology	6	16	11	0	33
Surgery	7	7	8	8	30
Gastroenterology	8	10	0	5	23
Cardiology	6	7	4	5	22
Radiology	5	5	5	4	19
Infectious diseases	6	7	3	3	19
Otolaryngology	0	7	8	0	15
Psychiatry	0	4	7	3	14
Public health	8	5	0	0	13
Laboratory, clinical biomedicine	7	3	2	0	12
Orthopedics	0	0	6	4	10
Dermatology	0	6	4	0	10
Ophthalmology	0	6	0	2	8
Neurology	0	4	0	4	8
Endocrinology	0	0	4	3	7
Rheumatology	0	0	6	1	7
Pulmonary medicine	7	0	0	0	7
Nephrology	0	6	0	0	6
Allergist	6	0	0	0	6
Microbiology	6	0	0	0	6
Hematology	0	0	3	0	3
Anatomic pathology	0	2	0	0	2
TOTAL	107	140	87	59	393

Source: Ministry of Health.

⁵⁰ Martin McKee and Judith Healy (eds.), *Hospitals in a Changing Europe*, European Observatory on Health Care Systems, Open University Press, Buckingham, 2002, pp. 232.

Table 3.18 - Approaches to Skill Mix and Substitution in Nursing

<i>Traditional.</i> Aides, assistants and auxiliaries, mainly trained on the job, performing simple nursing tasks in support of registered nurses
<i>Non-clinical assistant.</i> Clerk or aides role, mainly in non-clinical clerical or housekeeping work (or as a multi-skilled support worker)
<i>Technician or nurse technician.</i> Technical assistant or operating department assistant role for complex technological processes, assisting nurses
<i>Primary nursing partner.</i> Nursing assistant paired with nurse to maintain delivery of care by primary nursing
<i>Vocationally trained or qualified caregiver.</i> An addition to the traditional nurses' aide. Training of several weeks or months, in some countries leading to a vocational qualification. Caregiver undertakes nursing care responsibilities under direction of registered nurse

124. Medical colleges and universities, including training clinics are licensed by the MOE. There are strict guidelines for the recognition of staff as clinical instructors, which in some cases restricts the ability to provide hands-on clinical training, especially for general practitioners who may be undergoing retraining. The large number of people to be retrained as part of an effort to improve the skills and quality of the existing primary care physicians and nurses is taxing the current training system and will require an interim solution to allow for more clinical instructors.

F. CONCLUSIONS AND RECOMMENDATIONS

125. **Although it may be premature to say that there is a “crisis” in health human resources in Albania, there are clearly significant challenges that require concerted and ongoing analysis and action.** Aside from normal aging of the workforce and retirements, there will be increased pressures in the future on the retention of health sector staff, especially as other economic possibilities emerge. On the other hand, it is clear that the citizens of Albania perceive that quality and competence issues exist in the health care delivery system. Patients are already “voting with their feet” in bypassing general practitioners in favor of hospitals and specialist physicians. The demands for improved quality (as well as quantity) will surely increase as Albania moves closer to EU membership.

126. **The skewed geographic distribution of health sector staff will need to be corrected over time and form part of an overall health sector human resources planning exercise.** Coverage is relatively better for primary health care and other basic services, but is significantly skewed for specialists, dentists, and pharmacists. Although Albania is at the lower end of the coverage scale for most medical staff when compared to other countries in the region, overall staff productivity is low. Combined, these factors call for careful planning of both available and new health care staff. The high degree of specialization for physicians represents a significant challenge that needs to be managed, in terms of planning for new staff and in terms of limiting the negative impact of over-specialization and attrition. More attention may need to be paid to the level of specialization of the nursing workforce.

127. **There are clear indications of conflicts in the various motivating factors for health care personnel.** Different occupations elicit distinct gender preferences and have very different age profiles.

These occupations also have quite discrete distributions to various locations of work, and in turn, discrete earnings profiles. Overall, however, health sector wages can be seen as distinctly de-motivating, although some progress has been made in recent years in addressing wage levels. Where possible, health care workers appear to compensate for these wage levels by (i) limiting productivity, and (ii) extracting informal payments for services provided. Clearly, neither of these strategies is sustainable in the long run, and urgent action is needed to address each of them. This will become increasingly important as general wage levels continue to increase rapidly and the health sector struggles to keep pace. The aging of the health workforce will generate additional pressures, as an estimated 35 percent of physicians and 28 percent of nurses are due to retire between now and 2015.

128. **Aside from training and capacity building, health sector staff will need to be given specific incentives to improve their performance.** Changing the incentives structure and providing practitioners with the clinical and managerial skills needed to improve performance and better manage the available resources – human as well as physical and monetary – will be critical if the health sector is to improve its performance. The limited work undertaken so far to improve the incentives structure for primary care appears to have been effective in addressing distributional issues, but additional work is needed to tackle productivity, quality, and informal payment concerns.

129. **The need to improve the quality of care is pressing, particularly at the primary care level.** Upgrading the skill levels will place considerable strain on medical schools, professional associations and the MOH to ensure that there is sufficient staff to provide the skills upgrading and that the staff has the competence to provide a higher quality of care. The MOH is already responding to this through the creation of the Center for Continuing Medical Education, but much more needs to be done in this area. Quality and competence improvement are especially critical in the area of primary health care, where there is a major need to convince the public that primary care physicians are indeed capable of dealing with the vast majority of illnesses and treatments. This will require concerted efforts at broad based re-training of all primary care physicians and nurses, together with upgrading the available primary care equipment and assuring that payment reforms ensure the availability of adequate supplies at primary care facilities. The curricula for all health professions need to be carefully reviewed to ensure that the quality of teaching is up to international standards.

130. **Mechanisms are needed to promote continuing quality assurance at the provider level and to deal with providers who exhibit competence problems.** The anticipated moves towards increasing provider autonomy will require mechanisms other than those which might be available within an employer-employee model. Innovative approaches and institutional arrangements will be needed to ensure that competence issues are appropriately addressed. The ideal would be to have self-regulating professional organizations, but interim arrangements may be needed until professional associations are capable of assuming such responsibilities. Financial incentives will be needed to reinforce competence and high quality care. These will become even more important as the increased competence of health professionals makes them more attractive to neighboring countries that are able to pay more.

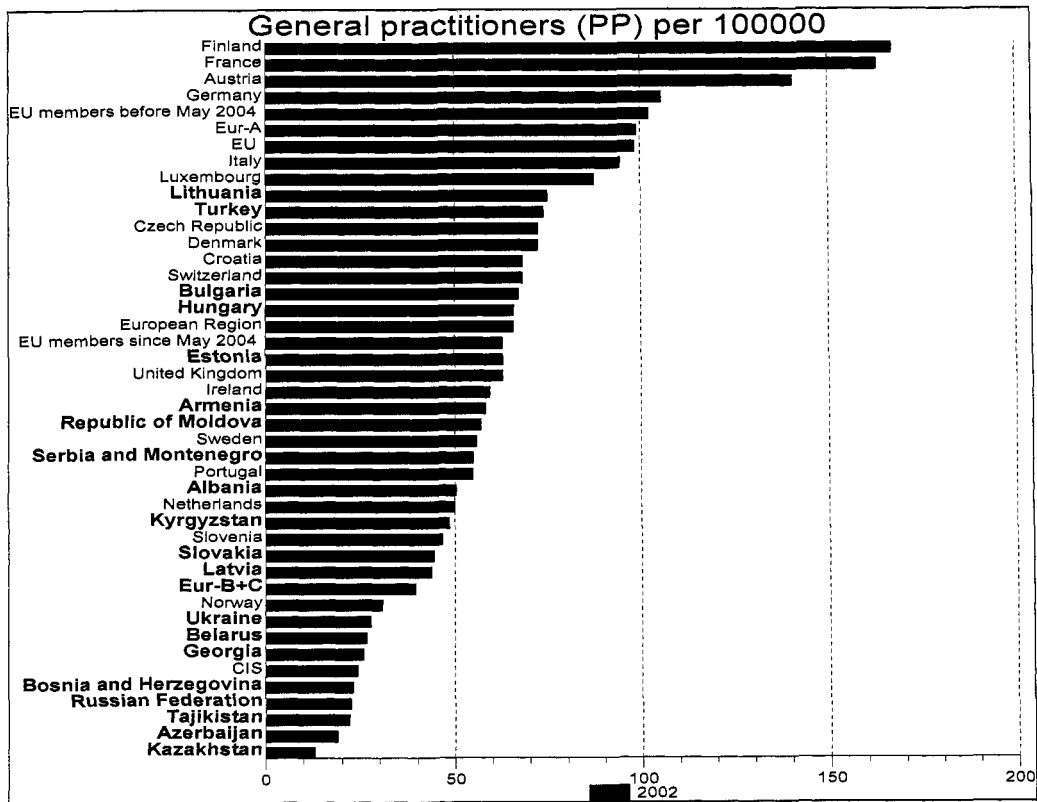
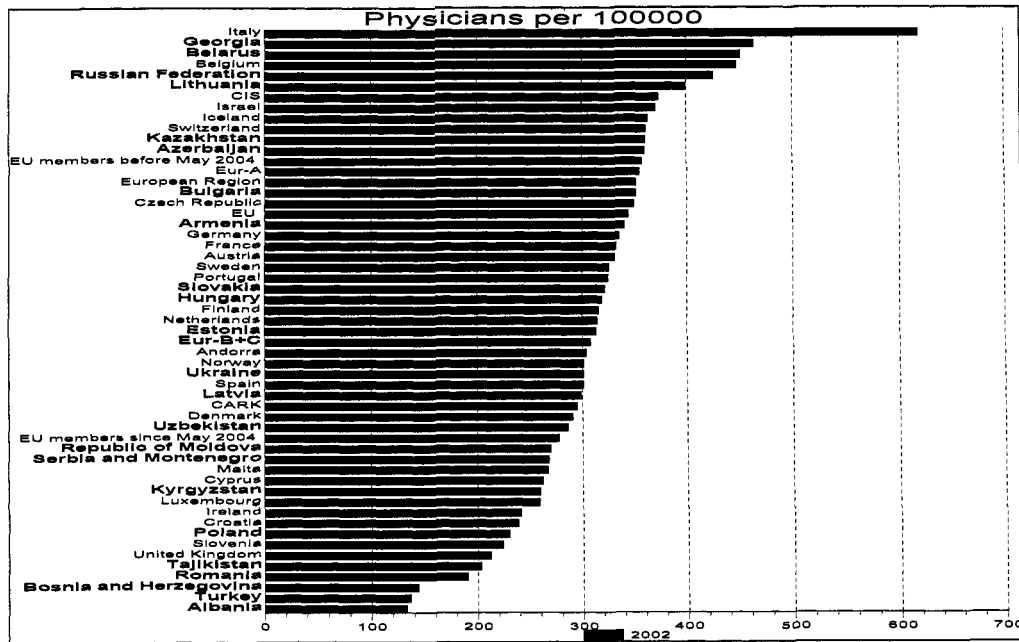
131. **The capacity for health human resource planning needs to be considerably strengthened across the health sector.** Given the move towards more policy-based roles for the MOH, a strong Human Resources Department is essential. In addition, an inter-ministerial Health Human Resource Working Group may be needed to serve as a forum for addressing issues that are beyond the strict purview of the MOH. Such a group would include representatives from the MOH as well as other key stakeholders, including the HII, the medical faculty and schools, and the MOE. Key health human resource issues, which must be examined closely by the MOH and might be referred to this working group, would include (but are not limited to) the following:

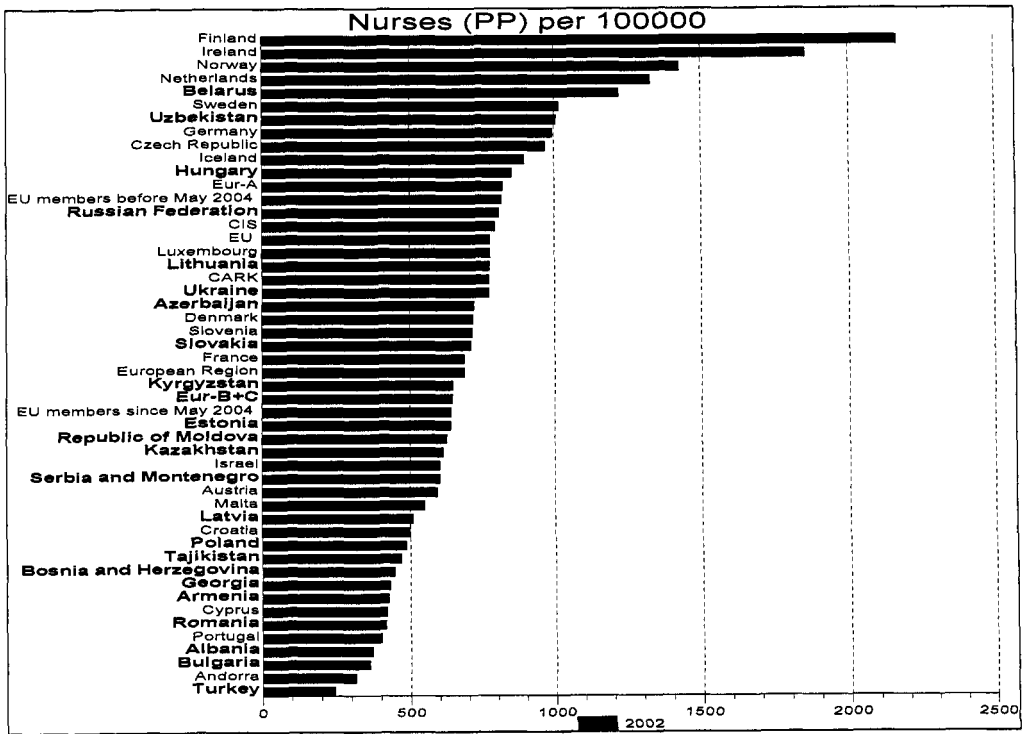
- The spatial distribution of health professionals, incentives for improving this distribution, and support systems for health professionals locating to more remote areas.
- The development of planning models which examine the supply, distribution, and retention of health professionals (including both normal retirement and attrition – deaths, emigration, movement into other professions, etc.).
- Appropriate levels of medical school enrollment, taking into account the results of the planning models and government policies regarding the desired levels of health human resources supply for each profession. For example, as shown in Box 3.1, keeping or increasing the supply of nurses will require substantial growth in nursing school output.
- Strategies for continuing medical education and improving the quality of medical school education in the direction of international standards.

132. **The role of the Ministry of Health in human resource planning will become even more important as formal provider autonomy is pursued as part of the Long-term Health Sector Strategy.** Under this strategy, increasing numbers of health care professionals would cease to be employed directly by the MOH, but would instead be self-employed professionals or staffs of autonomous health care providers that have contracts with the HII. This severing of the direct reporting relationship will make it necessary to develop other means of collecting information on the supply, production, and flow of health care professionals into and out of the health sector. Relationships will need to be cultivated with professional associations, medical schools, health professional unions, and other stakeholders, to obtain information and also to discuss issues and options. Information systems will also need to be adjusted to reflect the fact that all data cannot be extracted from existing Ministry human resources and payroll systems. These changes will also make it more difficult for the MOH to directly control human resources decision-making. This will result in the need to increase the overall level of consultation and collaboration with other stakeholders. At the individual provider level, human resource planning capability and capacity will need to be developed, and the managers of the new autonomous structures will have to be trained in a full range of human resource management approaches so that they can attract and retain the best staffs, and can deal with those who are not the best.

133. **Effective human resource planning will require strengthening the human resource database and building capacity in analyzing and utilizing data for policy decisions and planning.** A number of data sources were used in this chapter, including the WHO Health For All database, the Ministry of Education and Science statistics for medical education, INSTAT, and the MOH database. The MOH database is currently under development and there was some original concern that there might be data problems or inconsistencies. However, it is clear that the quality of the data will improve only if they are used for analysis and decision-making, and the Ministry has agreed to share these data.

Figure 3.12 - Comparative Physician and Nurse Coverage – Albania and Other ECA Countries





Source: Data Base "Health For All", www.who.dk/hfadb

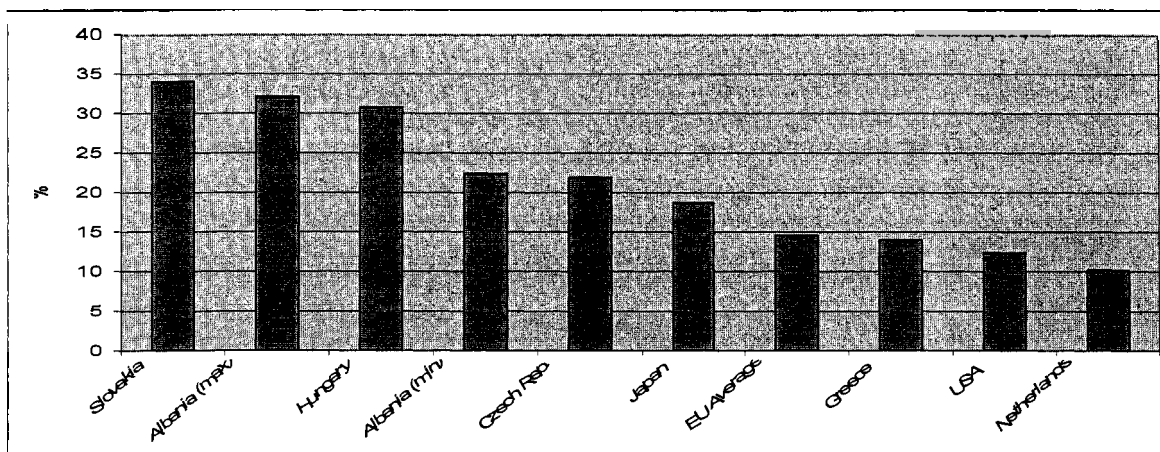
CHAPTER 4: PHARMACEUTICAL POLICY

A. INTRODUCTION

134. **The pharmaceutical sector in Albania is characterized by both public and private financing and delivery.** In 2004 there were approximately 1,000 pharmacies and 140 drug depots,⁵¹ of which, 700 pharmacies and 80 wholesale depots had contracts with the Health Insurance Institute (HII). Wholesaling and retailing are largely assured by the private sector. Profarma, the former monopolist and now one of three drug manufacturers in the country, was privatized in 2001 and produces generic drugs. There are 164 different dosage forms and package sizes from Profarma that are included in the positive list, but only a few of these are first choice alternatives for HII reimbursement or have won hospital tenders. A number of multinational innovative and generics companies maintain offices in Albania; others are represented by exclusive or non-exclusive importers.

135. Local importers estimate the overall pharmaceutical market in Albania at a wholesale amount of about US\$70 million with a current growth rate of 10 percent per year. This would amount to a retail market of about US\$93 million at officially set prices, though overcharging by retail pharmacists appears to have been a common practice and actual outlays for drugs may thus be higher, as suggested by household surveys.⁵² Reimbursements from the HII covered US\$35 million in 2004 and US\$42 million in 2005; about US\$7 million was spent by MOH for hospital drugs in 2004. The difference is made up by out-of-pocket payments. Based on the above data, pharmaceutical expenditure estimates account for between 23 and 32 percent of total health care expenditures in Albania (Figure 4.1).

Figure 4.1 - Pharmaceutical Spending as a Share of Health Spending



Note: The two values for Albania reflect the range of estimates for the drug market, the higher estimate is derived from household survey data on drug spending, the lower is the estimate of importers and the industry.

Source: OECD, LSMS

⁵¹ This number includes both importers and wholesalers. Wholesalers for the most part are defined as shortline.

⁵² Household surveys point towards annual expenditures of up to US\$130 million equivalent (LSMS 2002 based on average monthly household expenditures on drugs); this would be based on retail prices and would include overcharging by pharmacists. As this is self-reported, it may also include products which the industry may not consider as pharmaceuticals.

136. Box 4.1 summarizes the key areas for strategy development in the pharmaceutical sector outlined in the Government's Long-term Pharmaceutical Sector Development Strategy. Each point attempts to address problem areas in the pharmaceutical sector, which include legislation, monitoring and enforcement, professional and ethical behavior in prescribing and dispensing, drug pricing, and the quality of the drug supply. In the meantime, the Government has made significant progress in implementing this strategy. New tools for the management of pharmaceutical expenditures have been introduced without limiting choice, a new drug law has been passed, quality requirements for imported drugs have been tightened, a timeline for the local industry to implement European current Good Manufacturing Practice (cGMP) has been set and various procedures for licensing drugs and related businesses have been streamlined. However, challenges remain, mainly in the area of quality assurance, ongoing expenditure management, the building of technical and administrative capacity in the sector, the implementation of cGMP by the local industry, and the improvement of transparency in the operations of various drugs commissions.

Box 4.1 - Long-term Pharmaceutical Sector Development Strategy

The Ministry of Health of Albania, together with its two main partners, the World Bank and the World Health Organization, formulated and developed a strategy for the health sector, which included pharmaceuticals in April 2004. The strategies outlined in the area of pharmaceuticals were as follows:

- Improvement of pharmaceutical legislation with due consideration to the experience of the European Community. Formulation and approval of a national drugs policy document by the end of 2004.
- Strengthening of the capacity to monitor, control, store, and sell medicines. The reorganization of the National Medicines Control Center through the approval of new status, strengthening inspection, and expanding its activities through new structures of drug information, etc.
- Establishment and strengthening of the Order of Pharmacists as a partner in preserving professional ethics.
- Enhancement of the transparency of drug prices through improvements to the system of information and putting price tags on the labels in the Albanian language.
- Improvement of the technical conditions of retail pharmacies to achieve the standards of developed countries.
- Approval and use of Good Manufacturing Practice standards.

137. The following sections review each of these areas in more detail. Section B examines the updated legal framework for pharmaceuticals in the country, followed by a review of the current procedures for drug registration, price setting, and quality assurance in sections C through E. Sections F and G look at coverage and access for the part of the market covered by HII and MOH, while section H discusses hospital drug expenditures. Key areas of potential or actual corruption are raised in section I. Sections J and K consider the role and activities of physicians and pharmacists in this sector. Finally, section L makes some recommendations for further policy development and capacity building, reflecting back on the previous sections.

B. LEGAL FRAMEWORK AND PHARMACEUTICAL POLICY

138. **Albania strives to align its pharmaceuticals legislation and administration with that of the European Union.** Recent policy changes point in the direction of policies established in other European countries. A new drugs law, which seeks to address the key shortcomings of the 1994 Law on Medicines and to align Albania's drugs policy closer to that of EU countries, was enacted in early 2005. Among the key changes introduced by this legislation are the following:

- Simplification of the registration process for drugs approved in Europe or the United States
- Mandatory adherence of local producers to EU standards of current Good Manufacturing Practice within 2 years
- Increased independence of the National Center for Drugs Control (NCDC)
- Transformation of the current pharmacists association into the Albanian Order of Pharmacists, associated with the MOH
- Price negotiation for more expensive, single source medicines with importers/manufacturers, based on reference prices from other countries
- Introduction of a sticker system for drugs
- Detailed definition of a penal code for various types of violations, with penalties ranging from US\$100 to US\$10,000 and additional revocation of the professional license in more severe cases.

139. **While the new law addresses several key shortcomings of the previous legislation, it calls for a large body of secondary legislation to clarify the details of the many policy changes.** The law calls for over 20 by-laws, orders, and other technical documents to ensure adequate implementation. Many of these secondary acts still remain under development. Whether the intended results of this legislative initiative can be achieved will largely depend on these by-laws and the effectiveness with which they will be enforced and implemented. Overall, the swift updating and passing of a new drugs law is an encouraging sign of the Government's commitment to address weaknesses in the sector.

C. REGISTRATION AND LICENSING

140. **The Law on Medicines requires that all pharmaceuticals sold in Albania be registered and licensed by the National Center for Drugs Control.** Currently, decisions on drugs registration are made by the Nomenclature Commission appointed by the Minister of Health. The NCDC is under the responsibility of the MOH. The new law foresees an independent status for NCDC much like that of similar agencies in the EU. The objective would be to ensure the autonomy of its operations and decisions subject to appropriate oversight. The NCDC is financed primarily from the State budget, with secondary funding arising from drug registration (a registration fee US\$600 per drug plus a US\$200 renewal fee), the inspection tariffs of new facilities and drug analysis for private clients. As the wage level of the staff is very low, the secondary funding is used to pay bonuses and create a pool of funds to invest in the facility. The new law also foresees increased financial autonomy for the NCDC. This requires consideration of its independence in decision making. There should not be a financial incentive to register as many drugs as possible. Other agencies have solved this problem by charging small registration fees but somewhat higher maintenance fees for registrations. This is also fair to the manufacturers, who can decide to de-register drugs that do not fulfill their commercial expectations, without having to pay a large initial fee for getting market access.

141. **The number of registered drugs has increased substantially over the past decade, from 400 in 1994 to roughly 3,000 in 2005.** Albanian doctors and patients have access to a respectable portfolio of

well established generic as well as innovative medicines. Recently introduced simplifications of the registration process are aimed at encouraging pharmaceutical companies to register new drugs in Albania. Under the simplified procedures, drugs that are approved by a major agency such as the EMEA or FDA can receive registration and marketing authorization by means of acceptance of the respective certificate without further scientific or technical evaluation. Generics from other countries need to obtain a registration in an EU member country, or the United States, Canada, or Australia first in order to be registered in Albania. This takes into account the limited capacity of the Albanian authorities to verify quality standards. However, a clause that includes “Western Balkan countries with which Albania has ratified free trade agreements” is cause for concern, as it may create a loophole for lower quality products. Drugs that are on the market already do not lose their registration, but may have to meet the new standards for renewal, though the law is not explicit on this. Some unregistered drugs can still be used in the country with special ministerial permission, but the number has been reduced from about 50 to eight. The goal is to register all drugs that are required to provide state-of-the-art treatment and thus eliminate the need for special permissions.

142. **The licensing of private institutions, including manufacturers, pharmacies and drug depots, is the responsibility of the Licensing Commission of the MOH, although the new law foresees that this responsibility will be transferred to the Order of Pharmacists.** The Licensing Commission is required to approve the location and physical condition of the pharmacy. Licenses are now valid for 5 years, and in case of re-licensing for 10 years. The new drug law foresees that licensing will be transferred from the MOH to the Order of Pharmacists. As long as the relationship between the MOH and the Order is not clear and as long as by-laws or detailed operating procedures are not available, it is difficult to judge whether this is an appropriate solution. It will be important to have a clearly defined, transparent process and to separate the technical assessment from the approval of the license application.

D. PRICE SETTING

143. **Drug prices are set based on the CIF price submitted by the manufacturer, with added regulated margins for distribution and retail. Margins are relatively high and provide little incentive for the consolidation of a fragmented wholesale market** (see Table 4.1). For a number of expensive drugs with a significant impact on HII expenditure, NCDC and HII have entered into negotiations with manufacturers or importers, using reference prices from neighboring countries to demand lower prices. The selection of reference countries has been somewhat opportunistic to date, depending on good contacts with other administrations that have supplied price data. To ensure optimal outcomes, a more systematic approach using a potentially broader range of reference countries and independently provided data is recommended. To date, price negotiations have been partially successful, leading to estimated cost savings of up to US\$4 million based on 30 drugs.⁵³ It is expected that over time, with a growing market, the bargaining power will increase. Currently, manufacturers who cannot get a price acceptable for them may decide not to offer a particular product.

144. **No formal pricing algorithm is in place for multisource drugs.** However, the generic drug with the lowest price is given the top position on HII’s reimbursement list, meaning that it will have the lowest copayment and therefore potentially the biggest share of the HII financed sales volume. Thus, the reimbursement system stimulates price competition for generic drugs. To what extent this system leads to low prices on an international scale in spite of the small Albanian market requires further analysis.

145. **To increase the hurdles for illegal imports and to eliminate a widespread practice of overcharging patients for medicines, a drug labeling system has been introduced.** Each pack of

⁵³ Cost savings are based on estimates by NCDC management.

medicine is required to carry a label that states the retail price, the name of the drug, the importer, and the batch number. At the same time, a degressive margins system aimed at reducing somewhat the incentive to sell expensive drugs has been introduced (Table 4.1). Margins for importers, wholesalers, and retail pharmacists have been increased for the majority of drugs, while those for very expensive drugs and drugs that are sold in large volumes have been decreased. Overall, the margins are relatively high, reflecting the fragmentation of the market and a low absolute sales volume compared to more developed countries. The fixed margin system with comparatively high margins protects the current structure and offers no incentive to reduce fragmentation in the wholesale sector.

Table 4.1 - Degressive Margin System for Medicines

	Importer and wholesale margin	Retail margin
Very expensive drugs	8%	15%
	10%	20%
	15%	30%
Least expensive drugs	18%	33%

Note: Margins include a 4 percent tax at each step of the distribution chain: importer, wholesaler and pharmacists. The total tax, as a percentage of the retail price, amounts to roughly 10 percent.
Source: Ministry of Health.

E. QUALITY ASSURANCE

146. **The NCDC has limited physical and human capacity to undertake drug quality testing, resulting in limited drug quality assurance in the country.** There is no capacity for testing biologicals, including blood products or vaccines. Random testing is not undertaken unless a product is sent to the NCDC on the basis of a complaint. This is one reason for the assumed circulation of unregistered, counterfeit, and poor quality drugs within Albania. Occasional “market sweeps” carried out by pharmaceutical companies have found counterfeits to date mainly for “lifestyle drugs” such as Viagra. This means that a distribution network for counterfeit drugs exists, which could develop into a more serious problem once the market grows and becomes commercially more attractive. Inspectors who are responsible for enforcing regulations at pharmacies and drug depots are paid low salaries and do not have the necessary means (offices, cars, equipment) to adequately do their jobs. The NCDC has been unable to fill some of its open positions, as qualified candidates can earn a significantly higher income in the private sector.

147. **The consequence is a general lack of trust in the quality of drugs, in particular if they come from developing countries.** The perception that cheaper drugs from developing countries are of low quality is fueled by those who have an interest in marketing more expensive drugs imported from Western countries. This can trigger cost increases through the use of more expensive products from manufacturers in developed countries. The new registration requirements, which call for an EU certificate for drugs from developing country manufacturers, may lead to a partial correction of this perception, but better quality control in the market is essential for a complete system. Even the new stickers on the legally imported drugs could become subject to counterfeiting, as experience in other countries has shown. A system for quality testing of regular drugs should be introduced by regularly taking samples from batches at customs and from retail pharmacies and testing them for adherence to pharmacopeia standards. In the absence of local capacity, laboratory work could be contracted to a foreign supplier, as is done in several other small countries.

F. ACCESS AND COVERAGE

148. Household surveys indicate that about 40-45 percent of the population benefit from effective coverage under the mandatory health insurance system, indicating that the majority of the population pay for medicines out-of-pocket (see Chapter 5). While HII reimburses those covered for drugs on its positive list with varying copayments, an estimated 60 percent of the population pay for their medicines out-of-pocket. There is a significant coverage gap between urban and rural areas, which reflects income differences as well as access to formal employment.

149. The burden of paying for medicines falls excessively on the poor. As Figure 4.2 shows, the poor spend nearly twice as much of their permanent income on medicines as those in the upper income quintiles. Furthermore, due to more extensive HII coverage in Tirana, HII drug reimbursements benefit the population in Tirana disproportionately while regions with higher poverty incidences benefit less (Figure 4.3). This suggests that drug subsidies should be better targeted towards the poor and vulnerable, an issue which should be addressed within the framework of the overall planned health finance system reforms (see Chapter 5). To the extent that health finance reforms will extend drug reimbursement benefits to a larger share of the population, however, a more restricted approach to reimbursements will be required to control costs.

Figure 4.2 - Expenditure on Drugs, % Share Permanent Income

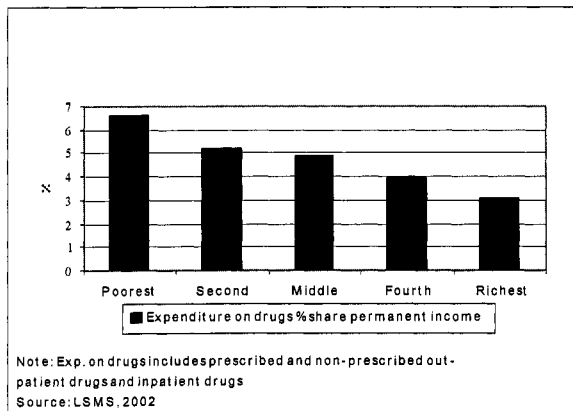
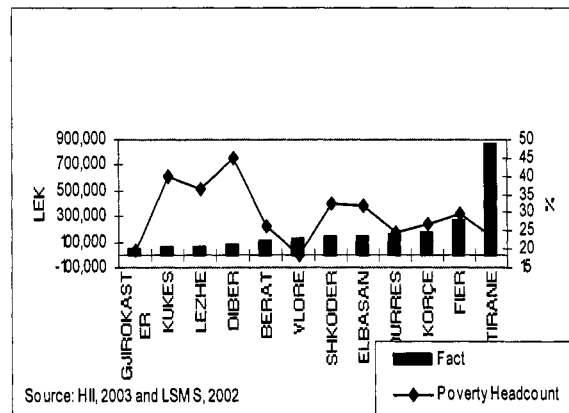


Figure 4.3 - HII Pharmaceutical Expenditure and Poverty Headcount by Prefecture



G. HEALTH INSURANCE INSTITUTE DRUG MANAGEMENT

150. The Health Insurance Institute (HII) reimburses a defined list of outpatient drugs for the estimated 40-45 percent of the population that benefit from effective HII coverage. The current reimbursement list includes 402 different active ingredients. Eight drugs were removed in 2004 because they were obsolete or because more cost-effective options became available. Decisions regarding inclusion on HII's positive list are made by the Reimbursement Commission established by the Minister of Health. Some concerns have been raised about the transparency of operation of this commission and its composition. Product selection for inclusion in the reimbursement list is not made according to clear and transparent criteria. The Reimbursement Department at HII manages the list, while the 12 regional HII offices are responsible for issuing the serial coded and colored prescription forms (colors signal the reimbursement level) and for reimbursing the contracted pharmacies. A controlling department analyzes prescriptions and investigates cases of alleged abuse or fraud. Contracting with physicians, pharmacies

and wholesalers allows HII to collect data for monitoring prescribing behavior and to catch those who try to play the system for their own benefit

151. **Pensioners, children under 12 months, orphans, disabled people, and war veterans are exempt from copayments, as are TB and cancer patients requiring TB and cancer drugs.** For all others, the amount of the copayment depends on the drug category. Six categories exist, ranging from 100 percent reimbursement for a small number of life-saving and cancer drugs to 50 percent for other drug categories. The inclusion of all pensioners in the group that receives 100 percent reimbursement was a key reason for the unprecedented increase in HII reimbursement expenditures in 2004. It also led to abuse. Many citizens who do not currently have an HII license, such as the unemployed, students, or those on social assistance, are theoretically entitled to HII coverage, which poses a risk for the future development of expenditures. A person with a newly diagnosed illness can register with the HII and receive immediate coverage without a waiting period or an exclusion of pre-existing conditions.

152. **In 2004, total HII drug expenditure accounted for 63 percent of HII expenditures and HII for the first time exceeded its budget for drugs⁵⁴** (Figure 4.4). The budget for pharmaceutical expenditures in 2004 was lek 2.8 billion; real expenditures were 3.5 billion, mainly due to the elimination of copayments for retired people, expansion of the reimbursables list and increased prescribing of innovative medicines. The deficit was covered by an MOH subsidy to HII. With the inclusion of more drugs in the reimbursement list and additional patient groups becoming exempt from copayments, the number of prescriptions as well as the percentage of prescriptions that are fully reimbursed has increased substantially over the last 2 years, thus contributing to the rapidly expanding HII drug outlays (Figure 4.5).

Figure 4.4 - Composition of HII Expenditures, 1995-2004

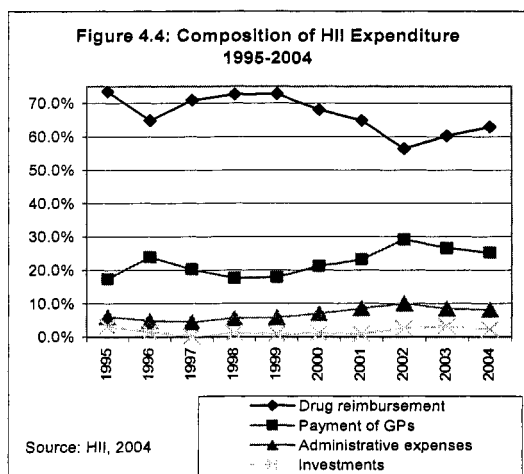
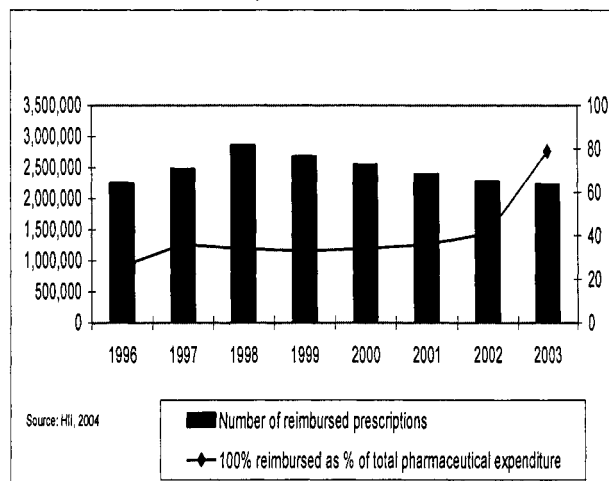


Figure 4.5 - Reimbursement Prescriptions, Headcount by Prefecture 1996-2004



153. **For multisource products, reimbursement is limited to the price of the cheapest alternative with the same ingredient and dosage.** The HII thus makes use of the reimbursement ceiling and internal reference pricing to control costs. If a more expensive brand is prescribed, the patient has to pay

⁵⁴ As discussed in Chapter 5, HII currently only covers salaries of GPs, drug reimbursements, and pilot activities in Durres Hospital and the Tirana region. This explains the high share of drug expenditures in HII's total expenditures.

the difference out-of-pocket. Higher priced, innovative products may be reimbursable as long as there is no generic on the market. Certain products need to be recommended by a specialist, but it is always the family practitioner who makes the prescription on the HII form.

154. **Recent developments show that there is a trend to prescribe newer and more expensive drugs, leading to substantial increases in reimbursement expenditures.** As Table 4.2 illustrates, six out of the top 10 reimbursed drugs by value fall into a single source category, thus invariably resulting in higher costs. To counter this development, the HII recently introduced informal “budgets” for contracted physicians. Physicians who deviate from the expected prescribing track are being audited by HII controllers. If the deviation is based on real medical need, the budget is increased. Otherwise, the physician is advised to adhere to rational prescribing rules. Obvious cases of wasteful over-prescribing or fraud (collusion with patients or pharmacists) will lead to fines and claims for compensation. If this behavior is repeated, or if the volume of the damages exceeds a certain amount, the contract with the physician is expected to be terminated. Similarly, contract pharmacists are increasingly controlled and have to repay damages when fraudulent behavior is discovered. Again, if the damages exceed a certain amount or a pharmacist is caught three times for minor violations, the contract is terminated. The extent to which this new system will be enforceable in the absence of updated patient enrollment lists and formally adopted treatment guidelines remains to be seen. The development of HII spending in 2005 suggests that these cost control measures are not sufficient to compensate for the recent inclusion of 72 new drugs in the reimbursement list. As the Government seeks to make health insurance coverage more widely accessible (see Chapter 5), concerted action will be required to contain reimbursement costs. In addition to physician budgets, this will require the training of physicians in rational prescribing, patient education, a review of the copayment policy, possible introduction of indications-based reference groups with generics determining the reimbursement price, and the revision of the positive list.

Table 4.2 - Top Ten Reimbursed Drugs by Value

INN Name	Indication	Quantity	Value (lek)
1. Enalapril 20 mg	ACE Inhibitors, Hypertension	21,351,668	233,511,574
2. <i>Risperidon 2 mg</i>	Neuroleptic, psychosis	967,302	224,430,982
3. <i>Valsartan 80 mg</i>	Angiotensin II antagonist, Hypertension	1,747,126	195,308,163
4. <i>Interferon beta</i>	Multiple Sclerosis	14,730	137,119,170
5. Amlodipine 10 mg	Calcium antagonist, hypertension	3,991,451	127,660,162
6. <i>Fluvastatine 40 mg</i>	Cholesterol lowering	1,519,703	122,557,294
7. Finasteride 5 mg	Benign prostatic hyperplasia	701,542	107,054,934
8. <i>Tamsulosin 0.4 mg</i>	Alpha-blocker, benign prostatic Hyperplasia	576,959	106,183,326
9. <i>Olanzapine 10 mg</i>	Neuroleptic, psychosis	101,448	95,819,722
10. H-insulin bi-phasic	Diabetes	87,766	90,516,449

Note: Single source drugs in italics.

Source: HII statistics, May 2005.

155. Reimbursed drugs are dispensed through a network of approximately 700 private pharmacies across the country, which have contracts with the HII. In rural areas, in the absence of a qualified pharmacist, a restricted list of drugs is stocked in what is called a drug agency staffed by a high school educated “assistant pharmacist.” Twice a month, pharmacists submit filled prescription forms to the local

branches of the HII for reimbursement, and once a month, the pharmacies are reimbursed. Each prescription form must be signed by the patient to verify that it was filled. For the most part, reimbursement by the HII to the pharmacies has occurred in a timely fashion; the daily penalty is 0.1 percent for each day that payment is delayed.

H. HOSPITAL DRUG EXPENDITURE MANAGEMENT

156. **Hospital drugs are covered through the MOH budget and in principle are provided free of charge to inpatients. In practice, many patients pay for drugs, as the budget financed supply of hospital drugs is insufficient to meet all patient needs.** Drugs are financed as a budget line based on historical costs. However, hospitals decide how much of this budget line is actually spent on drugs. Roughly 20 percent of all hospital expenditures are on inpatient drugs but the trend has been increasing upwards. Yet many patients are nevertheless required to purchase the drugs they need for inpatient treatment out-of-pocket.

157. **To increase the efficiency of hospital level drug procurement, the MOH has organized centralized tenders for hospital drugs since 2002.** Hospitals annually send their requests to the MOH for both the types and the quantity of the drugs they will require at their institution based on historical use; historical patterns will not necessarily reflect actual need in a given year. Hospitals tend to overstate actual need, as they generally receive a lesser amount than requested. These requests are then filtered by the MOH committee. Drug utilization in hospitals has not been optimized to minimize variations and ensure best practice. Current estimates of volume and the associated volume guarantee to suppliers are problematic. One option to address this problem may be to not guarantee the volume in the supplier contract but only the exclusivity of the suppliers, a practice utilized by some other countries (e.g., New Zealand). Tenders following Albanian procurement law are organized annually. It is estimated that the centralized tenders have resulted in five to six competitors, on average, presenting per class offering discounts generally reaching 30 percent. A common complaint is on the quality of drugs being procured by the MOH through the centralized tender. This may be an issue of perception, as an estimated 70 percent of supplies are won by suppliers from India and China. This stresses the need for a more visible quality assurance system and for physician and patient education.

158. As drug distribution was problematic and partially undermined by corruption in the first 2 years of the centralized tender process, in 2004, the MOH hired Fufarma⁵⁵ to distribute drugs to all hospitals. Fufarma is now responsible for accepting the shipments from wholesalers and ensuring complete delivery to the hospitals. The current impression is that this system works better and limits the losses due to corrupt practices. By some accounts, savings so incurred may be as high as 25 percent of the tender volume. However, in the long term it can be problematic to create a distribution monopoly.

159. **Hospital drug stock management systems are outdated and leave room for inefficiency and abuse.** The management of drugs is not computerized in most hospitals. Ward requests are sent to the hospital pharmacy on a daily basis. Bookkeeping is done manually. There are some exceptions, for example, at the central pharmacy of the Tirana University Hospital where Pharmaciens Sans Frontiers helped to computerize the stock management; however, the department units often lack similar equipment or infrastructures in which such equipment would work. In the central pharmacy of the Tirana University Hospital, each department has its own pharmacy, which orders supplies from the main hospital pharmacy warehouse. Many of the department pharmacies at this hospital are not integrated within the main department but are physically in separate buildings. Although labeling the drug boxes has helped to

⁵⁵ Fufarma is a remnant of the former public distribution system and is 65 percent private and 35 percent state owned.

identify hospital drugs, theft is nevertheless still a problem, calling for an upgrade of the in-house stock management systems.

160. **The process of centralized tenders is further driving the need to develop more uniform prescribing protocols to minimize variation and ensure standards of care across hospitals.** The Faculty of Medicine is currently engaged in developing protocols, which are to be implemented, initially at least, at the Tirana University Hospital. The challenge will be in the wider dissemination and implementation of these protocols in other hospitals. This should form an integral part of a concerted effort to improve the quality of care through the development of treatment protocols and mandatory continuous education for physicians.

I. CORRUPTION AND HARMFUL BUSINESS PRACTICES

161. The pharmaceutical value chain is prone to some degree of corruption and collusion in many countries. But even perfectly legal behavior of market participants can have unwanted economic consequences, leading to wasteful spending, if the incentives are not carefully aligned with the desired outcomes.

162. **The Government has implemented several steps to fight corrupt practices in the pharmaceutical sector.** The recent streamlining of the drugs registration process has eliminated “gray areas” that would provide opportunities for preferential treatment based on bribes. Similarly, centralized tenders for hospital drugs and the outsourcing of hospital drug distribution are positive steps to minimize the potential for corruption, as is the introduction of the labeling system for hospital and retail drugs. However, several weak points persist.

163. **Several special commissions operate as formal decision making bodies. Concerns have been raised about their composition and lack of transparency in decision making.** The Nomenclature Commission decides on the registration of drugs; the Licensing Commission endorses licenses for all medical and pharmaceutical professionals and businesses; and the Reimbursement Commission approves new drugs for inclusion into the HII reimbursement list, sets prices and reimbursement limits, and eliminates outdated or economically obsolete drugs. Concerns have been raised about the transparency with which these commissions operate. Some commissions have 30 or more members, mostly representatives of the medical profession, academia, the Ministry, and other administrative bodies. However, the Reimbursement Commission, for example, has two representatives from pharmaceutical firms. This raises conflict of interest concerns. Given the authority of these commissions, stakeholder concerns about the lack of transparency and potential conflict of interest should be addressed promptly. In particular, their membership should be revisited to avoid professional bias and conflicts of interest, clear standard operating procedures for decision making should be adopted, and transcripts of their meetings should be published.

164. **Another area for potential corruption is the enforcement of licensing requirements.** Low salaries of inspectors and existing relationships with inspected entities may compromise objectivity and lead to the overlooking of infractions or the acceptance of bribes. Measures to limit corruption in this field include rotation of inspection areas and spot checks of inspection quality by the chief inspector or an independent auditor. Offering a bribe or accepting it must carry the risk of prosecution, punishment, and termination of employment or professional license.

165. **With the introduction of centralized tenders for inpatient drugs, the MOH has taken an important step towards reducing the scope for corruption.** The MOH tenders are annual, following the requirements of the procurement law to purchase medicines nationally according to defined inpatient

need. Indicators that the objectives are being met through this process are the reported 30 percent discounts on drug prices during the first 2 years of centralized procurement, as well as the fact that almost two-thirds of contracts were awarded to low-cost generic manufacturers. There have been some reports of corruption at the hospital level where the selected drugs are delivered and paid for. Allegations have been made that some hospital managers were refusing delivery of the selected drugs without first being paid a kickback. To overcome this problem, the MOH in 2004 contracted Fufarma, the quasi-public drug distributor, to deliver the selected drugs to the hospitals.

166. **The theft of hospital drugs for resale in pharmacies or through unofficial channels has been a source of concern.** The MOH now requires drug suppliers who win tenders to ensure that the packages sold to hospitals are specially labeled. Poor stock control procedures at most hospitals significantly contribute to hospital theft.

167. **In the area of HII-reimbursed pharmaceuticals, additional control measures have been introduced to eliminate collusion between doctors and pharmacists and abuse of the system by patients.** These measures appear to be adequate, although this will remain an ongoing struggle. Product selection for the reimbursement list is not made according to clear and transparent criteria. Although there are no direct allegations of corrupt practices, increasing the transparency of the committee's decision making should be a priority.

168. **Concerns over certain business practices arise at the pharmacy level.** Pharmacists still have a financial incentive to influence product selection towards a more expensive drug, as they are paid a margin that is a percentage of the product price. They may run out of stock for the cheapest product or suggest to the patient to take a "better quality" product, of course at a higher price. Recently increased controls by the HII may help to reduce this problem. To address this problem in a more fundamental way, other countries have adopted alternative payment models for pharmacists, such as flat dispensing fees (introduced in Germany and the United Kingdom). The disadvantage of these models is that there may be a steep increase in the retail price for low cost drugs. However, where a pharmacist is reimbursed the list price for a drug plus a flat fee, there is an incentive for the pharmacist to negotiate a discount on a list price, part of which can be recaptured by the government either through a repayment from the pharmacist or a subsequent lowering of the list price of the drug. In Albania, changing the payment structure for pharmacists to a flat fee could have an unwanted effect on access for the poor unless concerted efforts are made to target public drug reimbursement subsidies to lower income groups.

169. **Pharmacies and wholesalers have reportedly overcharged for medicines in the past. The recent introduction of price labels made this more difficult.** Reports from December 2005 suggest that the system is accepted and HII is able to enforce the contracts with pharmacies that require them to sell only labeled products.

J. PHYSICIANS AND PRESCRIBING

170. **Concerns about the quality of prescribing by physicians persist.** The Order of Physicians appears to receive complaints frequently from patients regarding prescribing problems. To what extent these are due to perceived quality problems for generic drugs is unknown. In addition, some pharmaceutical manufacturers or importers allegedly use questionable marketing practices to influence prescribing behavior. All this has raised awareness for the need for additional post-graduate training of physicians to improve rational prescribing. A formulary summarizing information on drugs and treatment protocols on the HII reimbursement list has been compiled. This has been widely distributed to general practitioners. Although the distribution has not been combined with extensive training-related activities, anecdotal evidence suggests that it has been an important reference tool during prescribing.

171. **Concerted efforts are needed to integrate training in rational prescribing into broad-based efforts to upgrade the clinical skills of primary care physicians through continuous education.** For inpatient drug use, the Tirana University Hospital and the Faculty of Medicine have been developing standard treatment protocols for a wide range of diseases. However, as long as these protocols are not mandatory, their uptake and use in clinical practice will remain limited.

K. PHARMACY AND PHARMACISTS

172. The Department of Pharmacy of the Faculty of Medicine at the University of Tirana offers a five-year pharmacy degree program. This is the only training center in Albania and it turns out about 60-70 pharmacy graduates annually. Pharmacy education is lacking in terms of physical infrastructure, including equipment and reagents. While some steps have been undertaken to adapt training to better meet the needs of modern pharmacy practice, cooperation with the private sector remains minimal and there is no experience in industrial production. Students undertake only a half-year of actual clinical practice. Many pharmacists have not been equipped with adequate management training and ongoing professional training is minimal. It is anticipated that the Order of Pharmacists will take a lead role in developing professional education activities with the Department of Pharmacy, when it assumes the responsibility for licensing.

173. **There is a shortage of hospital pharmacists and of private pharmacies in rural areas.** The salary of a hospital pharmacist amounts to less than half of what a private pharmacist can earn, making it difficult to fill hospital pharmacist positions. In rural areas, pharmaceutical services are in general covered by pharmacy assistants who have 4 years of high school training in this capacity. They work in so-called drug agencies, which can dispense a limited list of drugs.

174. The new law sets some restrictions on the structure of the pharmacy market. It defines a target of one pharmacy per 3,000 population and limits pharmacies to be at least 150 meters apart. With the current number of 1,200 pharmacies, this ratio has, on average, already been reached. However, the density in urban areas is higher, whereas rural areas are under-served. The law also contains a restriction of one pharmacy per pharmacist and prohibits the establishment of pharmacy chains. Although in the short term this may offer some stability to the market, in the longer term this may only serve to generate economic rents to the pharmacist, thus limiting price and quality competition. On the other hand, forming procurement cooperatives to get better prices appears to be permitted. This could allow for substantial cost savings. However, the fixed margin system with comparatively high margins protects the current structure and offers no incentive to reduce the fragmentation in the wholesale sector.

L. REMAINING CHALLENGES AND RECOMMENDATIONS

175. **Albania has taken important steps towards enhancing the functioning of its pharmaceutical sector but further challenges remain.** The MOH, NCDC and HII have, in a coordinated effort, made good progress in establishing the tools for public expenditure management of pharmaceuticals through the introduction of a basic reimbursement list, reference pricing, and centralized tenders for hospital supplies. The new drug law addresses a number of remaining problems and introduces additional measures to improve efficiencies. The following list highlights the remaining challenges and makes recommendations for further steps to strengthen the management of the pharmaceutical sector.

176. **The capacity for quality assurance throughout the distribution chain should be strengthened to address the perception that sub-standard or even counterfeit drugs are being sold in Albania.** Samples should be taken from batches at customs and from retail pharmacies and tested for adherence to pharmacopeia standards. In the absence of local laboratory capacity, qualified laboratories abroad could be contracted to carry out such tests. This is likely to be more cost effective than establishing local capacity. Another long-term option might be to combine efforts to upgrade the capacity of pharmacist education and training at the university with efforts to establish a local capacity for drug testing. A drug quality capacity at the university could serve a dual purpose. It could be utilized to train pharmacy students in drug quality testing according to Good Laboratory Practices and could also provide quality assurance analysis under contract to the NCDC. Irrespective of how the laboratory services will be secured, inspectors will need to be trained in sampling methods and record keeping for the purpose of drug quality monitoring. Compensation and the provision of the equipment needed to do this job should be improved. Inspectors should rotate between different areas so that pharmacists cannot predict which inspector is coming. Inspections and drug test outcomes should be communicated regularly in the media, including information about the consequences if sub-standard or counterfeit drugs are found, to reassure the population that the Government takes drug quality issues seriously.

177. **The status and role of the NCDC should be clarified promptly** by finalizing the necessary by-laws. The regulations should be explicit about the fees, which the NCDC is eligible to receive for the performance of defined services. To relieve pressure on financial incentives to register as many drugs as possible, a system could be considered whereby lower registration fees, but somewhat higher maintenance fees for registrations, are charged. In the medium to long term, consideration should be given to expanding the NCDC's activities into other areas, including the monitoring of adverse reactions of medical products and medical devices; the control of advertising and promotional activities; the issuing of certificates for the export of medicinal products and devices pursuant to WHO requirements; the collecting and processing of statistical data on trade and consumption of medicinal products and medical devices; the provision of information and promotion of the rational use of medicinal products and medical devices; and the integration into international networks of information on medicines and medical devices.

178. **As HII reimbursement coverage expands to a larger share of the population, additional measures for cost containment are necessary.** Health finance reforms aimed at improving the insurance coverage of a wider population group, together with stricter registration requirements for generic drugs, are likely to put additional pressure on drug expenditures. Some low cost generics may not fulfill the EU registration criteria, which would exclude them from the market in the medium term. Steps will therefore need to be taken to ensure cost containment. This will require keeping a close watch on prescription patterns, reviewing the copayment structure and the copayment exemption policy, and conceivably also tightening the positive list of reimbursable drugs. The tendency to replace older, but still effective and safe, drugs with newer, more expensive treatments leads to faster than expected cost increases. Other countries have introduced indication-based reference groups with a reimbursement price based on a generic option. For example, cholesterol lowering treatments such as simvastatin, lovastatin, and atorvastatin are all in one group, with the reimbursement price limited to the lowest cost option, usually a generic within this group.

179. **The structure and level of margins for distributors and pharmacists should be further reviewed.** The current margins are relatively high compared to those of other countries. There are many small importers and wholesalers in Albania. Concentration of this fragmented sector would allow for scale economy induced cost savings, but the current fixed margins create little incentive for consolidation and savings. Pressure could be increased by setting a total margin only and consecutively lowering it step by step over a couple of years. The introduction of a total margin would require importers, wholesalers and pharmacists to negotiate their share among one another. This would probably lead to vertical integration (to importers taking over some of the distribution as well, or vice versa) and the entrance of

pharmacists into purchasing cooperatives. The current margin structure for pharmacists is still creating an incentive to dispense higher priced drugs. Other countries have introduced obligatory substitution (unless excluded by the physician, the pharmacist has to dispense the cheapest available product in a given category). Some have also introduced flat dispensing fees instead of a percentage margin. However, flat dispensing fees generally lead to price increases for cheaper drugs while significantly lowering the prices of expensive drugs. This would require ensuring that the measures are introduced to protect the poor from price increases for cheap drugs.

180. Drug price negotiations with importers of innovative drugs could be further strengthened by adopting a more standardized approach to the use of reference prices. The selection of appropriate reference countries can be broadened if data from an independent database are used (for example, from the Austrian Health Institute – <http://www.oebig.at/>). This would allow for a more informed negotiations basis, which is of particular importance given the small Albanian market and the ensuing limited leverage for negotiation. It may also be worth considering alternative approaches such as negotiating a rebate for HII reimbursed drugs while maintaining a set price on the official list. Companies are worried about low published list prices, because other countries can make reference to these. But if they receive an acceptable list price, they may be more open to offering a rebate for the sales that are covered by social insurance. This practice could be implemented in the form of a refund at the end of every fiscal year, based on the real sales under HII reimbursement. Such a refund could also be volume based, meaning that the rebate would increase if a certain agreed volume were exceeded. Volume based rebates are a mechanism to “insure” HII against cost explosion due to a too enthusiastic uptake of new drugs. It must, however, be noted that any HII rebates would not benefit all those who purchase drugs out-of-pocket, and thus might again have a negative effect on lower income groups, unless measures were put in place to target drug subsidies towards low income groups.

181. The composition and modus operandi of the main commissions dealing with registration, reimbursement of drugs, and licensing of professionals should be reviewed. Membership in commissions should exclude any members that have a potential conflict of interest, such as industry representatives on the Reimbursement Commission. The decision making of the commissions should be based on objective criteria and transparent standard operating procedures. Operating procedures, as well as the results of decision making, should be made public to enhance the trust in the professional integrity of these bodies.

182. Hospital drug management capacity needs to be improved to enhance efficiency and reduce the scope for abuse. In the medium term, modern IT based solutions should be considered within the framework of the development of overall improved hospital management information systems.

183. Physician capacity for rational prescribing should be strengthened as an integral part of efforts to improve the quality of care and establish a continuous education system for physicians. Standard treatment guidelines for primary care and hospital care should be developed, starting with the most important conditions. Guidelines would then need to be formally recognized and adopted and their utilization encouraged through their integration into the continuous education curriculum. Drug selection for the reimbursement list and hospital formularies must be based on these treatment guidelines.

184. The quality of pharmacist education and training needs to be strengthened (graduate, postgraduate, and continuing education) and the training resources need to be enhanced. The rapid development of the private sector and the introduction of modern treatments in Albania make it urgent for the academic side to grow and adjust.

185. The marketing practices of the pharmaceutical companies and their representatives should be regulated according to European Federation of Pharmaceutical Industry Associations (EFPIA)

standards. Adoption of the EFPIA code could be made a licensing requirement for manufacturers and importers. In the absence of regulatory capacity, self-regulation can work if there is independent validation (for example, through a review board that has a majority of non-industry and non-health care participants including consumers) and if sanctions are in place for companies that violate the code.

CHAPTER 5: HEALTH SECTOR FINANCING

A. INTRODUCTION

186. A key objective of the health policy of many countries, including Albania,⁵⁶ is to ensure that its population has adequate access to essential health care services and is protected to the extent possible from the impoverishing effects of health expenditures. The Government can substantially influence these objectives with its health finance policy. The extent to which adequacy in access to health care and financial protection from health risks are achieved is substantially influenced by the level of resources allocated to the health sector, the way these resources are mobilized, the extent to which they are pooled and pre-paid, and the way in which they are allocated to providers. The mixture of public and private spending, the share of pre-pooled funds versus out-of-pocket spending at the point of service, the mechanisms utilized to allocate public and pooled funds and to pay providers all have a direct bearing on the effectiveness and efficiency with which a health care system achieves health outcomes and affords its population protection from the impoverishing effects of health shocks.

B. STRUCTURE OF HEALTH CARE FINANCING IN ALBANIA

187. **Albania spends around 6 percent of GDP on health care, which is below the Central and East European average, but is about average for a lower middle income country** (Table 5.1). Of these expenditures, only somewhat over one-third come from the central government budget, while about 60 percent come from the private sector and 4 percent come from donors (Figure 5.1).⁵⁷ Albania's per capita expenditure on health care (about US\$126 in 2004) is somewhat below that of other countries in Central and South East Europe, but compares favorably with that of many CIS countries.

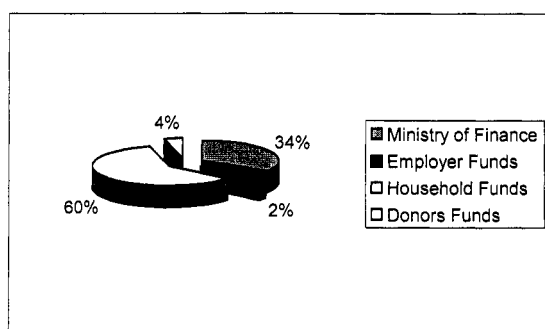
The share of public sector spending in total health expenditures is below that of other countries with similar income levels.⁵⁸ The low share of public sector spending and the concomitant high share of unpooled out-of-pocket spending has serious equity, poverty, and health sector stewardship implications. The share of private sector health care spending (61 percent) in Albania is considerably higher than in many other countries in the region (ECA average 33 percent) and above the average of middle income countries (lower middle income country average 54 percent, upper middle income country average than 42 percent). Furthermore, essentially all private sector spending is out-of-pocket expenditure by households at the point of service. This compares to a significantly lower share of out-of-pocket spending of 36 percent and 82 percent for high income and lower middle income countries respectively. The need for high out-of-pocket expenditures at the point of service results in access barriers for low income households and threatens to throw these into poverty when they face health shocks (see below). Furthermore, the higher the share of unpooled out-of-pocket spending, the less possibility the Government has to steward the sector and use fiscal instruments to drive health system reforms, which are critically needed to improve the quality of service, sectoral efficiency and, ultimately, health outcomes.

⁵⁶ See Government of Albania, Health Sector Strategy, 2004.

⁵⁷ Based on Albania, National Health Accounts, Ministry of Health, 2004.

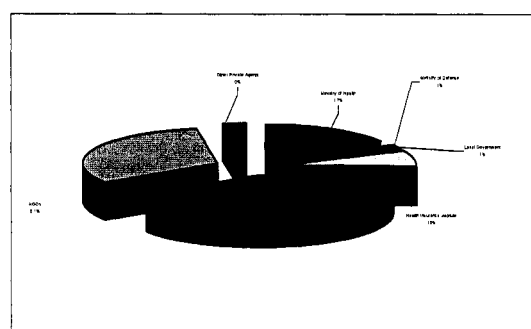
⁵⁸ International evidence suggests that a country's ability to collect public revenues as a share of GDP increases as GDP increases. Since the ability to allocate public funds to health care is a function of a country's overall fiscal capacity, a comparison of public sector funding as a share of GDP among countries of similar income levels is more appropriate than a mere geographic comparison. Similarly, a comparison of the share of total public sector funding going to health care rather than public health expenditures as a share of GDP is more adequate in this context.

Figure 5.1 - Sources of Health Sector Funding



Source: Albania NHA, 2003

Figure 5.2 - Financing Agents, 2003



Source: Albania NHA, 2003.

Table 5.1 - Health Sector Financing – Albania and International Comparisons, 2002

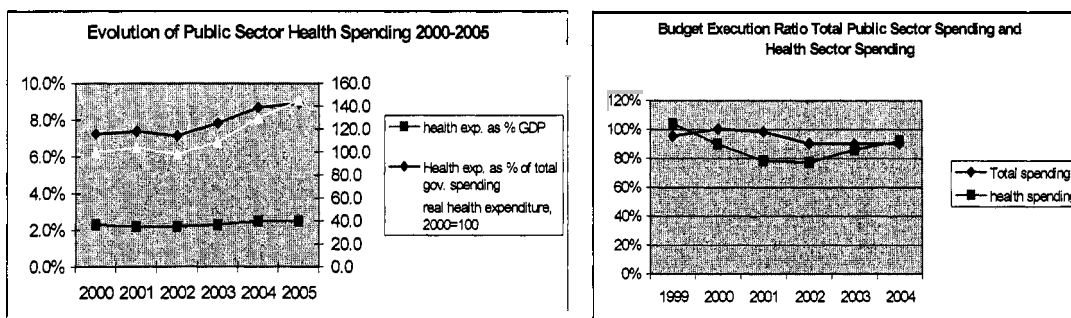
	Health Expenditure % of GDP	Government expenditure as % of total HE	Private expenditure as % of HE	Health expenditure as % of total Government Spending	Total HE per capita in PPP\$	Total HE per capita \$	GDP/capita \$ Atlas method
SEE							
Albania	6.1	38.7	61.3	7.1	309	94	1,740
Bosnia	9.2	49.8	50.2	8.8	322	130	1,530
Bulgaria	7.4	53.4	46.6	10.1	499	145	2,130
Columbia	8.1	83.0	17.0	20.4	536	151	1,810
Ecuador	4.8	36.0	64.0	8.8	191	91	1,830
Khazakstan	3.5	53.2	46.8	8.9	128	56	1,780
Macedonia	6.8	84.7	15.3	14.0	341	124	1,980
Romania	6.3	65.9	34.1	12.7	469	128	2,260
Serbia& Montenegro	8.1	62.8	37.2	10.7	305	120	1,910
Thailand	4.4	69.7	30.3	17.7	321	90	2,190
Turkey	6.5	65.8	34.2	10.3	420	172	2,800
Europe&Central Asia	7.2	66.0	33.0	12.1	1,350	1,117	n.a.

Source: WHO NHA database, WDI 2005, Albania MOF

C. TRENDS IN PUBLIC SECTOR SPENDING

188. **Public sector expenditures on health as a share of GDP have risen only slightly in the last 5 years, from about 2.2 percent in 2000 to an expected 2.5 percent in 2005 (Figure 5.3) and remain substantially below European and middle income country averages.** The 2.5 percent of GDP which Albania's Government spends on health care compares to an ECA average of 4.8 percent and a lower middle income country average of 3.3 percent. Health sector expenditures have increased from a low 7.2 percent of consolidated government spending in 1999 to an expected 8.9 percent in 2005, thus still remaining substantially below that of most other countries in Europe as well as in the CIS (average 12.1 percent). Although Albania's NSSD has singled out health as a priority sector together with education, the budget execution ratio for health has remained substantially below that in most other sectors over the past 5 years, with the notable exception of 2004. This suggests that, over most of the past 5 years, health sector expenditures were not protected when resource constraints called for overall budgetary adjustments. To the extent that the bulk of the adjustments were made on the investment side, the poor budget execution ratio may also partly be due to inefficient capital budget execution by the MOH.

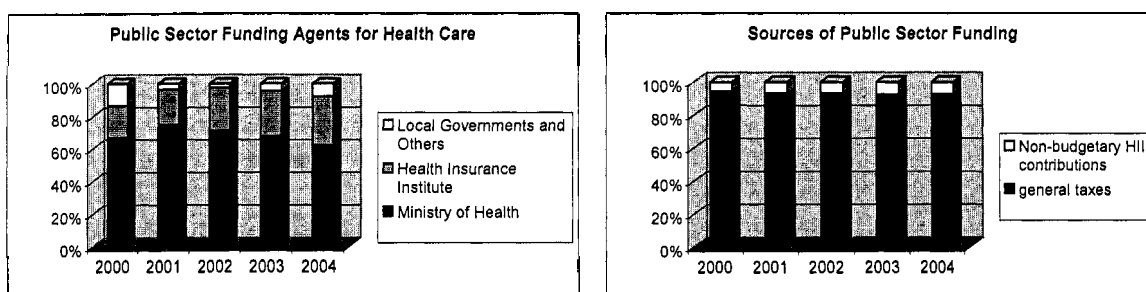
Figure 5.3 - Public Sector Expenditures on Health and Budget Execution



Source: Ministry of Finance

189. **Sectoral funding remains fragmented and financing responsibilities have changed often over the past 5 years.** The main source of public sector funding is the state budget, which over the past 5 years has accounted for about 93 percent of public spending on health care while about 7 percent has come from non-budgetary sector employer and employee contributions to health insurance⁵⁹ (Figure 5.4). The principal public sector financing agents are the MOH (about two-thirds of public spending) and the HII (somewhat over one-quarter). The Ministry of Defense and the local governments have each averaged another 3 percent over the past 5 years. The financing responsibilities of local governments in the health sector have frequently changed over the past few years, which at times has led to uncertainties and irregular resource flows, particularly at the primary care level. Current public sector funding assignments are summarized in Table 5.2. The fragmentation and frequent changes have tended to create uncertainty among providers and patients, leaving ample room for abuse. They have also prevented the introduction of a coherent system of provider payment mechanisms, which could encourage increased efficiency, quality improvements, and coherent provider performance oversight.

Figure 5.4 - Sources and Funding Agents of Public Health Expenditures



⁵⁹ The 93 percent of public sector funding through the budget includes budgetary transfers to the HII and health insurance contributions made for budget paid public sector employees.

Table 5.2 - Public Sector Funding Responsibilities in the Health Sector

	MOH	MOD	Local Gov.	HII
Primary Care and Public Health	- salaries of staff other than GPs, except Tirana region - operating costs, except Tirana region		- investments in primary care facilities and facilities maintenance through central government grants	- GP salaries - all PHC in Tirana
Hospital Care	- all hospital care except Durres and Military hospital	- military hospital		- Durres Hospital - 12 high cost tertiary care diagnostics for HI beneficiaries
Prescription Drugs				- reimbursements for HI beneficiaries

190. **Overall, public sector spending has become somewhat more skewed towards hospital spending over the past 5 years.** Albania allocates about half of all public sector spending on health to hospital care (compared to an OECD average of 38 percent). The trend over the past 5 years has been one of a growing share of public spending going to hospital care and prescription drugs, at the expense of primary care. Recurrent expenditures for hospital care posted a real growth rate of 26 percent, compared to primary care and public health expenditure growth of 12 percent. The decreasing emphasis put on financing of primary care is of concern in an environment in which the population has lost trust in primary care owing to quality concerns and the frequent absence of essential supplies at primary care facilities. Of particular concern is the fact that the budget execution ratio for non-wage recurrent costs at the primary care level has consistently been below that of hospital care. This has resulted in many primary care facilities lacking even the most essential supplies to effectively provide care, particularly in rural areas. This has contributed to a situation in which much of the population, particularly in rural areas, circumvents primary care facilities in search of better care at higher end facilities. The decrease in emphasis on primary care spending appears to go counter to the Government's stated objective to strengthen the role and performance of primary care to enhance overall cost-effectiveness in the use of limited public sector resources. It also raises questions of how efficiently public sector funds are utilized.

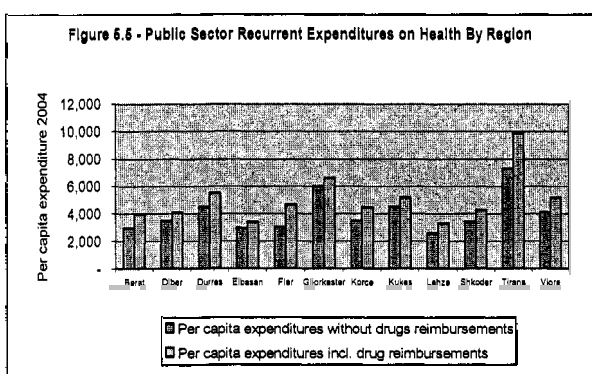
191. **HII's expenditures on the reimbursement of prescription drug have doubled over the past 2 years.** Spending on HII reimbursed prescription drugs now accounts for almost 20 percent of public sector recurrent spending on health care, although it benefits only a minority of the population. The sharp increase in spending is due to a combination of factors, including an imprudent expansion of the positive list of HII reimbursable drugs, an increase in prescription numbers and cancellation of copayments for most beneficiaries, including pensioners (see Chapter 4). Since currently only about 40 percent of the population benefits from HII financed drug reimbursements, any move towards expanding the breadth of coverage for this benefit will need to be accompanied by measures to enhance cost containment on drug reimbursements and a review of the copayments system.

Table 5.3 - Allocation of Public Sector Recurrent Health Expenditures by Level of Care, 2000-2004

	2000	2001	2002	2003	2004	2005	Real Increase 2000-05	% of total 2000	% of total 2005
Primary Health Care and Public Health	5,083	5,068	4,813	5,722	5,932	6,603	30%	41%	32%
Hospital Care	5,083	6,911	7,133	7,433	8,100	9,844	94%	41%	48%
Prescription Drugs	1,705	1,572	1,482	1,914	2,888	3,560	109%	14%	17%
Administration and Other	603	499	380	707	516	469	-22%	5%	2%
Total	12,475	14,051	13,807	15,775	17,436	20,477	64%	100%	100%

Source: MOF, HII, MOH, TRHA.

192. **Public sector spending on health per capita varies markedly by district and region.** Even when Tirana, where the country's tertiary care facilities which serve the entire country are located is excluded, public sector recurrent expenditures on health care per capita vary by a factor of two between

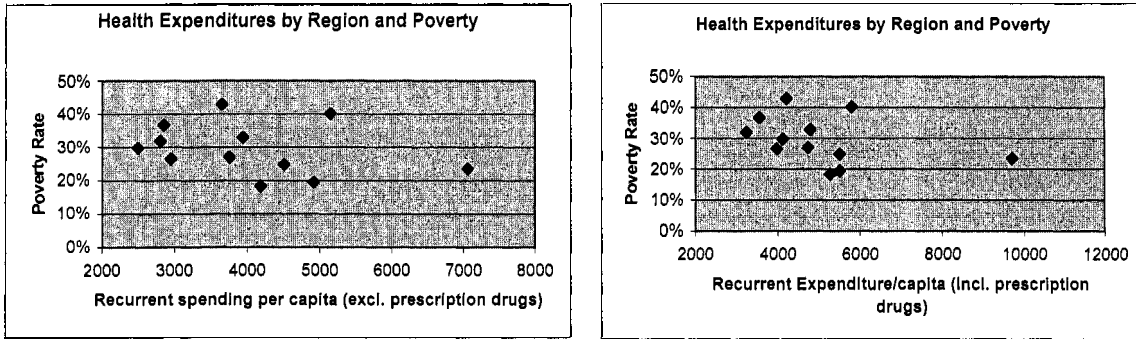


the district with the highest and the district with the lowest expenditures. This is the result of resource allocation decisions being input-based rather than output- or needs-based. Budgetary allocations are made on the basis of historical costs. As Chapter 3 has shown, the marked variation in medical personnel density and hospital bed density by regions leads to high regional variations in per capita expenditures. There are three instances where such a variation may be called for: (i) when certain regions show significantly worse health indicators than the rest of the country; (ii) when public sector resources

are specifically targeted towards the poorest regions to ensure adequate financial protection in the poorest households; and (iii) when certain districts or regions are home to hospital facilities which provide services to a wider area (e.g., multi-regional or national hospitals). None of these appear to be driving the geographical variation in health sector spending in Albania.

193. **Public sector spending on health care is not targeted towards the regions with the highest poverty incidence.** On the contrary, the lower the poverty rate is, the higher the public sector health care expenditures appear to be (see Figure 5.6). This is even more marked when health insurance financed reimbursements for prescription drugs are taken into consideration. Therefore, public funds appear overall not to be utilized to ensure adequate financial protection for those most vulnerable to health shocks. This is further confirmed by the fact that out-of-pocket expenditures for health care have a significant poverty impact and the share of low income households with catastrophic health care expenditures is significantly higher than that of higher income households.

Figure 5.6 - Recurrent Expenditure on Health and Poverty Headcount by Region



D. HEALTH INSURANCE

194. Although over two-thirds of funding for health insurance comes from general tax revenues, only about 40 percent of the population appears to effectively benefit from health insurance coverage. The HII is funded by payroll tax contributions (3.4 percent of salaries or wages up to a maximum of three times the annual average personal taxable income), contributions of the self-employed and farmers (between 3 percent and 7 percent of the minimum wage, depending on the category), and budgetary contributions for the dependent population. The dependent population includes all children under one year, pregnant women, war veterans, the disabled, the unemployed and recipients of social assistance, cancer patients, people under compulsory military service, and pensioners.

Figure 5.7 - Source of Health Insurance Revenues

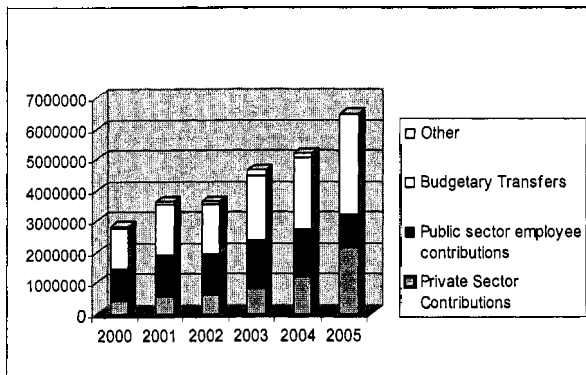
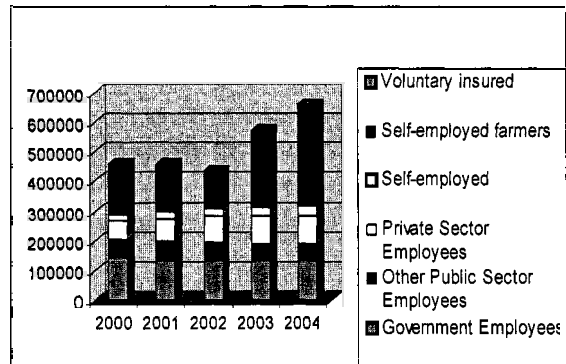


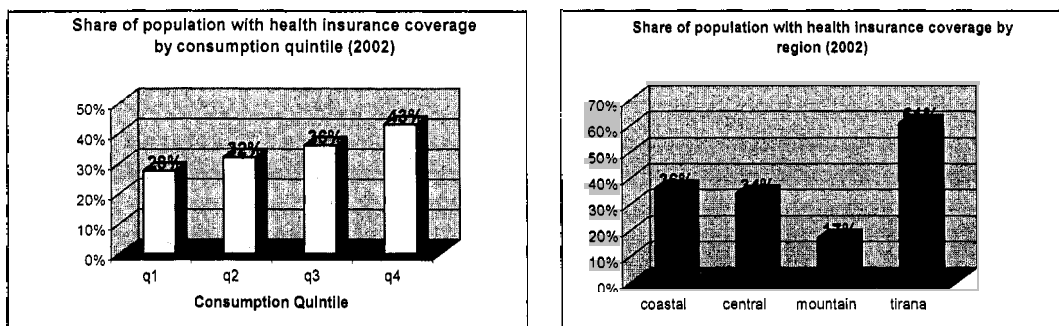
Figure 5.8 - Health Insurance Contributors



Source: HII.

195. **Despite a 40 percent increase in the number of contributors over the past 5 years, including a marked rise among farmer contributors, active contributors still account for only about one-third of the active workforce.** The number of those covered by the state remains uncertain.⁶⁰ While the law provides for the entire population to be covered, household surveys suggest that only about 40-45 percent of the population state that they are covered by health insurance.⁶¹ Household survey data show significant regional variations in the health insurance coverage rate, with over 60 percent of the population living in Tirana reporting that they have a health insurance booklet, but less than 20 percent of the population in the mountainous region being covered (Figure 5.9).

Figure 5.9 - Health Insurance Coverage by Consumption Quintile and Region



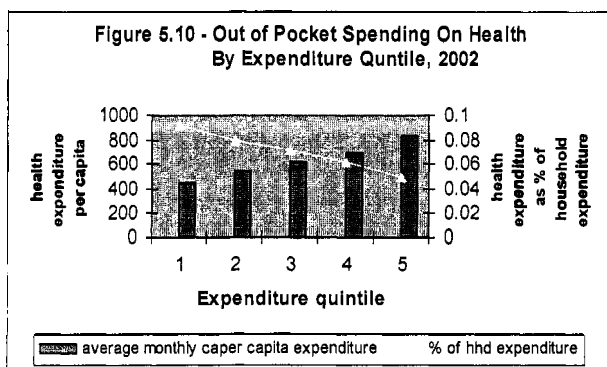
Source: LSMS 2002

196. The overall low reported coverage is due to two factors. First, a large share of the active labor force works in the informal sector and thus avoids contribution payments. Second, anecdotal evidence suggests that knowledge of health insurance benefits appears limited among a significant part of the population. Thus it is likely that a significant share of those who are in principle covered through the state do not know and make use of their rights. Contribution incentives for the active labor force are overall weak, as the scheme provides limited benefits, covering only primary care (outside polyclinics), reimbursement of prescription drugs of varying degrees, and certain high end diagnostics procedures. Outpatient care in polyclinics and hospitals, and inpatient care, are in principle free of charge if a patient has been referred by the primary care physician, though household surveys show that the vast majority seeking care at these levels incur significant out-of-pocket payments. Household survey data (see Table 5.4) show that the possession of a health insurance booklet does not significantly lower the amount of out-of-pocket expenditures for outpatient care nor does it affect the likelihood of having to pay for care, particularly outside Tirana. This suggests that doctors at primary care facilities tend to not enforce fee payments for those without insurance, while those with insurance incur expenditures for drugs, diagnostics and informal payments similar to those without insurance.

⁶⁰ HII data on the total number of people covered are unreliable, adding up to a significantly higher number than the total population of Albania.

⁶¹ LSMS 2002: 40 percent coverage, LSMS 2004: 46 percent coverage; similar results (40 percent coverage) were found by PHR+ in a survey covering Berat, Fier, and Kucova.

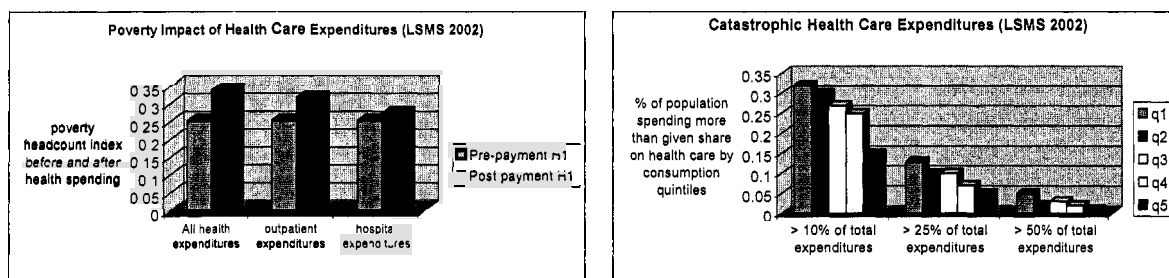
E. PRIVATE EXPENDITURES ON HEALTH CARE



income quintile spends only about half as much on health as the top quintile (Figure 5.10 and Table 5.4). The Albania Poverty Assessment has shown that health expenditures have a strong impact on poverty, with the poverty incidence increasing from 25 to 34 percent if out-of-pocket health expenditure is subtracted from household income.⁶² Outpatient care expenditures have a greater impact on poverty than hospital expenditures, owing to their more frequent occurrence. However, when low income households have to face hospitalization, the

income shock is catastrophic, with the average hospital payment amounting to over four times the monthly per capita income of the lowest expenditure quintile. Lower income households also have a significantly higher likelihood of incurring catastrophic health care expenditures than better off households, as even relatively modest outpatient care expenditures can amount to an excessively high share of a household's budget. The average out-of-pocket expenditures for one episode of outpatient care amount to 50 percent of the average monthly per capita expenditure of the lowest consumption quintile, suggesting that even the need for a simple outpatient care visit can result in catastrophic expenditures for the lowest income groups.

Figure 5.11 - Poverty Impact of Health Expenditures



Source: World Bank Poverty Assessment

198. **Out-of-pocket payments for outpatient care are highest in the mountainous region and lowest in Tirana, and the likelihood of paying for outpatient care is lowest in Tirana.** The share of

⁶² The pre-health care payment poverty is measured as the percentage of people whose household expenditure falls below the poverty line. Post-health care payment poverty is measured as the percentage of people whose household expenditure net of health care expenditure falls below the poverty line. The rationale being that expenditures on health care could have been used for other essential household consumption. See World Bank, Albania Poverty Assessment, 2003.

those who pay for outpatient care, particularly medicines and treatment costs is lower in Tirana than in the rest of the country, while the amounts spent on treatment, informal payments and transportation are markedly lower in Tirana than elsewhere (Table 5.4). This results in significantly lower average out-of-pocket payments for outpatient care in Tirana. This can, to some extent, be explained by the fact that those in rural areas, including the mountainous region, tend to circumvent primary care and go straight to a polyclinic or the hospital where they incur higher costs for treatment and also spend more on transportation. In Tirana, on the other hand, the majority of the population seeks care at the health center, a reflection of a somewhat better enforced referral system for those covered by health insurance and of the higher incidence of health insurance coverage.

Table 5.4 - Out-of-Pocket Expenditures for Outpatient Care

(Lek paid per episode of care for those who made payments)									
<i>Quintiles</i>	<i>treatment</i>	<i>gift</i>	<i>drugs</i>	<i>laboratory</i>	<i>transport</i>	<i>Total</i>	<i>% who paid (excl. transport costs)</i>	<i>payment per episode as % of monthly per capita consumption</i>	
1	319	92	1,071	144	212	1,838	95	50	
2	344	147	1,256	218	312	2,277	96	40	
3	312	146	1,276	238	266	2,238	97	30	
4	294	153	1,244	334	205	2,231	94	22	
5	314	158	1,314	383	188	2,356	95	15	
Total	319	135	1,217	240	244	2,155	95	30	
% of Total Payment	15	6	56	11	11	100			
<i>Region</i>									
Coast	244	186	1,435	346	151	2,362	98	31	
Central	372	104	1,058	169	308	2,013	94	29	
Mountain	396	150	1,239	196	401	2,382	98	42	
Tirana	206	43	1,146	254	13	1,663	87	20	
Urban	255	109	1,101	283	85	1,834	94	23	
Rural	354	148	1,279	217	331	2,329	96	35	
<i>Health Insurance Status</i>									
No insurance	329	150	1,213	241	267	2,200	96	30	
insurance	308	117	1,222	239	218	2,103	95	24	

Source: LSMS 2002.

199. **The share of those who pay for outpatient care varies little across consumption quintiles.** While the lowest income quintile spends somewhat less in absolute terms per episode of care, there is little variation across the other income groups. The lowest income group appears to spend somewhat less on drugs and informal payments than the upper income groups. This is probably a reflection of the fact that the poorest income groups do not always fill their drug prescriptions, owing to financial constraints. Health insurance does not appear to significantly affect the amounts paid for outpatient care, with the exception of Tirana, where lower overall payments and the lower likelihood of having to pay can be explained partly by the higher incidence of health insurance coverage and partly by substantially higher per capita public expenditures on primary care. Another study, using data from Berat, Fier, and Kucova,

only found that health insurance coverage reduces the likelihood of having to pay for drugs, as well as the amounts paid.⁶³ Overall, by far the highest share of out-of-pocket payments (56 percent) goes to drugs, followed by consultation fees (15 percent) and diagnostics (11 percent), while 6 percent goes to informal payments.

200. **Although Albanian legislation provides for free inpatient hospital care for all, out-of-pocket expenditures in the event of hospitalization are substantial, with informal payments accounting for at least one-quarter of all payments.**⁶⁴ The available data on out-of-pocket spending for hospital care must be utilized with caution, owing to the relatively low occurrence of hospitalization and the ensuing small universe of observations in household surveys.⁶⁵ The LSMS data indicate that virtually everyone who is hospitalized incurs substantial out-of-pocket expenditures, averaging about 21,000 lek. While low-income groups appear to pay less than upper income groups, the catastrophic extent of these expenditures for low-income groups is substantially more marked than for upper-income groups. Hospital expenditures for the lowest income quintile amounted to more than four times the monthly per capita expenditure, while they reached about twice the monthly per capita expenditure of the top quintile.

Table 5.5 - Out-of-Pocket Payments for Hospital Care

Quintile	Treatment	Gift	Drugs	Diagnostics	Transport	Total	% of monthly per capita expenditure	% of monthly household expenditure
1	6,492	4,057	2,212	790	1,450	15,001	405%	61%
2	10,684	4,373	3,716	2,082	1,980	22,835	398%	69%
3	5,204	5,521	3,680	1,304	1,504	17,213	229%	43%
4	15,839	5,843	3,683	948	1,603	27,916	279%	61%
5	13,531	8,121	4,497	1,377	2,257	29,783	187%	41%
% of total payment	41%	26%	17%	7%	9%	100%		

Source: LSMS 2002.

201. **Informal payments account for a relatively modest share (6-7 percent) of out-of-pocket expenditures for outpatient care, but for at least one-quarter to 40 percent of inpatient care payments.**⁶⁶ The system of informal payments is partly encouraged by an ill-defined and enforced copayments policy. Overall, about 30 percent of those seeking outpatient care report making informal payments, but almost 60 percent of those seeking inpatient care state that they made a “gift.” It is likely that the share of those paying informally for hospital care is even higher, as at least a part of reported

⁶³ Hotchkiss et al. (2004).

⁶⁴ While the Health Care Act provides for free care, government decisions allow for charges for certain diagnostic procedures. Patients are often also asked to provide their own drugs.

⁶⁵ The LSMS 2002 covered about 17,000 individuals in 3,600 households and asked each individual whether she/he had been hospitalized over the 12 months preceding the survey, in the affirmative, information on hospital expenditures was collected. Of the surveyed population, 4.6 percent reported hospitalization. This compares to administrative data of 8.4 admissions per 100 people. However, the LSMS did not ask about re-admissions or multiple admissions, and thus a somewhat lower rate than the administrative data would suggest is to be expected.

⁶⁶ Reported informal payments based on the LSMS amount to 26 percent of inpatient care. However, it is quite likely that a share of the 41 percent reported as treatment costs also constitutes informal payments, when one considers that hospital treatment is in principle free of charge. A PHR+ survey in Berat, Fier, Kucova found similar results for primary care (informal payments = 7 percent of the total out-of-pocket expenditures) but showed that patients reported paying almost 40 percent in informal payments for inpatient care (Hotchkiss et al, 2004).

treatment costs may also be informal payments (LSMS 2002).⁶⁷ Informal payments for hospital care create a significant burden on low income groups seeking care, amounting to over 100 percent of the monthly per capita consumption of households in the lowest income groups (Table 5.5). Because they are not known in advance, the uncertainty surrounding informal payments creates a significant additional burden on those seeking care in hospitals. Furthermore, as these payments do not go to the providing institution, they are not subject to the policy and managerial controls of the health system and are a major source of lack of transparency. The system of informal payments is partly encouraged by an unclear copayments policy, which often blurs the distinction between formal and informal payments.⁶⁸ The Government's efforts to change the provider payment system to induce providers to attain higher efficiency and improved performance risk being thwarted if the problem of informal payments, particularly in hospitals, is not addressed. Experience elsewhere has shown that it is possible to reduce informal payments when this issue is addressed as an integral part of health finance reforms (see Box 5.1).

Box 5.1 - The Kyrgyz Experience with Reducing Informal Payments in Hospitals

Health finance reforms in Kyrgyz aimed at improving the efficiency of resource utilization, transparency and improving equity of access to health care. The Government decided to pool all public resources (state budget, local government budget, health insurance funding) under the Health Insurance Fund (HIF) and to make the latter the sole purchaser of health services. A basic package of health benefits to which the entire population is entitled was clearly defined, with supplemental benefits accruing to those who paid insurance contributions and certain vulnerable groups. The package provides for free primary care from HIF contracted family physicians, and specialist outpatient and inpatient care on referral with copayments. Those who have made contributions to HIF are entitled to lower copayments and an outpatient drug benefit package. The introduction of formal inpatient copayments has been a central part of the reform with the objective of reducing informal payments in hospitals so as to increase transparency and uncertainty and subject these funds to the managerial control of the health system. Copayment revenues stay at the hospital which can utilize them based on allocative guidelines issued by the MOH/HIF (50 percent for drugs, 20 percent for food, 20 percent for supplemental staff salaries, 10 percent for the reserve fund to provide free drugs to the poorest population). Furthermore, HIF provided exemptions or lower copayments for those covered under HIF (including low income vulnerable groups) were significantly better applied, thus lowering out-of-pocket spending by those who qualified (including low income groups). Thus, by formalizing patient payments, new formal hospital revenues became subject to policy and management directives, which resulted in targeting these payments to key inputs. An evaluation of the reform in districts where it has thus far been implemented shows encouraging results. While patients' total out-of-pocket expenditures did not decrease, surveys show that the share of patients with foreknowledge of the amounts to be paid upon hospitalization tripled following the reforms, out-of-pocket expenditures for drugs and medical supplies for hospital care decreased by over 90 percent and informal payments made to hospital staff dropped by over 70 percent.

Source: Kutzin, J. and S. Chakraborty, Background Paper for Health Chapter of World Bank, Kyrgyz Public Expenditure Review, 2003.

⁶⁷ Given that inpatient treatment is free in principle, the relatively important reported treatment costs for inpatient care may well contain additional informal expenses.

⁶⁸ For example, if a patient requires certain treatments and the supplies are not available at the providing institution, patients may be required to either purchase their own supplies or reimburse the attending physician or nurse for the supplies which she/he purchased from own funds. This may be considered as an informal payment by some.

F. PROVIDER PAYMENTS

202. **The current provider payment system, fragmented at the primary care level and input-based for specialist and inpatient care, fails to make providers accountable for performance.** Resource allocations which are driven by staffing norms and infrastructure fail to give providers any incentives to work efficiently and provide a high quality of care. Several steps have been undertaken to attempt to move towards more performance-based payment mechanisms. However, the measures introduced have not been comprehensive and financing remains fragmented, with the result that primary care providers are not accountable to anyone in particular for the results which they achieve. Primary care general practitioners are paid by the HII on a modified capitation basis (base salary plus capitation supplement depending on location and registered patients), which in principle depends on the number of registered patients. In practice, however, the registration system is not properly implemented, as demonstrated by the fact that the number of people that GPs declare as being registered amounts to about 1 million more than Albania's total population. While the system allows for higher pay in remote areas to attract and retain GPs in such areas, it does not include any rewards linked to performance and quality targets. Furthermore, the fact that other primary care personnel and operations and maintenance costs are paid from a different source, gives primary care physicians limited control over the performance of their entire operation, thus diluting the incentives which the HII payment system was intended to introduce.

203. **With the exception of Durres Hospital, hospital providers are financed through the MOH with an input-based line item budget.** Hospital managers have limited expenditure management and managerial autonomy. They can hire and dismiss staff within the MOH-set norms with ministerial approval and can select vendors for supplies other than pharmaceuticals. However, they cannot reallocate funds across budget categories and adjust the overall staffing levels according to a given hospital's needs. Input-based financing gives providers no incentive to improve performance, nor does it lead to resource allocation based on outputs or local needs. This has resulted in skewed regional resource allocation and lack of provider accountability for low quality performance and a high level of informal payments at the hospital level. The lack of a formal copayment system for hospital care further perpetuates informal payments.

G. STRENGTHENING THE HEALTH FINANCING SYSTEM

204. **Albania's health finance system is afflicted by several key shortcomings that need to be addressed.** They include (i) the high share of out-of-pocket spending on care outside an overall financing framework resulting in the Government's limited ability to exercise its stewardship function and creating serious access barriers for low income households; (ii) the inequitable allocation of public sector resources; (iii) fragmentation in public sector financing, resulting in inefficiencies, lack of accountability and uncertainties; and (iii) provider payment systems which fail to harbor incentives to improve accountability for performance. To address these issues, a considerable change in the health sector financing system is required. The suggested reforms are discussed under the key health sector financing functions, resource mobilization, the pooling of funds, purchasing, and payment for health services. They center around the following:

- Eliminating the fragmentation of health care financing by pooling all public sector resources for health care under one financing agency which would allocate the funds and purchase health services on behalf of the population.
- Relying on general taxation rather than payroll tax contributions as the main, if not the sole source of public sector funding for health care, and channeling budgetary funds allocated for

health care through a designated agency (the HII), which would utilize these funds to purchase health care services directly from providers.

- Separating the financing from the provision of health care and using the HII as an agent to purchase health care services on behalf of the population directly from health care providers.
- Allocating funds for health care based on population health needs rather than the existing infrastructure and staffing distributions.
- Changing the provider payment system from an input-based system to an output- and performance-based system, and gradually granting health care providers increased autonomy over resource use.
- Formalizing out-of-pocket payments for services, including inpatient hospital care, by clearly defining what public funds will pay for in full, for which services users will pay a copayment and for which services users will fully bear the costs, with a system of lower copayments and concurrent higher budgetary payments for clearly defined low income target groups.
- Gradually improving the balance of public and private out-of-pocket spending by increasing the share of public sector spending in total health sector spending in the medium to long term.
- Developing a well defined provider network map, which will help guide future investments in line with population needs, particularly for the hospital sector.
- Establishing a system of regular monitoring and analysis of the resource flow in the health sector.

G.1. Resource Mobilization

205. **The high cost and uncertainty surrounding the need for curative health procedures call for a mechanism to protect individuals from unwarranted health shocks.** In countries with a relatively low per capita income and substantial poverty incidence, even expenditures for relatively low cost interventions can result in catastrophic expenditures for low income households. Therefore, financial protection from impoverishment through health shocks and the desire of most societies to ensure equity in access to health care make pre-payment for health care and pooling of these prepaid funds an essential instrument of protection against health shocks. Typically, these pre-paid funds are pooled by a third party, which then purchases a set bundle of health services on behalf of the population which has made pre-payments. Insurance against the risk of health shocks does not necessarily require that individuals pay direct contributions to a health insurance organization. Pre-payment for health care and the pooling of funds can also occur through general taxation. The concept of insurance simply implies that the population is provided with financial protection from health shocks with pre-paid and pooled funds. In health care systems where the funding comes from general taxation, pre-payment occurs at the time of payment of non-earmarked tax revenues to the government. In other words, it is possible to create a system in which funds are pooled and channeled through a purchaser without altering the current sources of public funds, if budget funds for health are pooled in the HII.

206. **Albania should continue to rely on general taxation as the main public source of funding for health care rather than increase payroll tax contributions for health care.** To date, 93 percent of public sector spending comes from general taxation, while only 7 percent comes from non-budgetary payroll tax contributions to HII. Only one-third of the active labor force participates in what is by law a mandatory health insurance scheme, suggesting large contribution evasion. The MOH and the HII have proposed that payroll tax contribution rates for HII be raised to 7.5 percent in an attempt to increase the amount of funding available under health insurance and expand the depth of health insurance coverage to hospital care. Proponents of this proposal foresee that increased payroll tax contributions for health

insurance would lead to a gradual reduction in the budgetary financing of health care with a concurrent increase in funding from higher payroll tax contributions. This proposal is not advisable for several reasons:

- (i) International experience has shown that health care systems which rely primarily on payroll tax contributions to fund health care result in considerably greater inequity in access to care than systems in which the main source of public funding is general taxation. This is particularly the case in low and middle income countries where a large share of the labor force is either in the informal sector or unsalaried. In such situations, payroll tax based contribution systems create incentives for non-participation in the scheme and for adverse selection. The latter means that only those who expect to have significant health care outlays will tend to participate, leading to an overall drag on the system. Those in good health often perceive the benefits as less than the required contribution and thus opt not to contribute. Low income households generally cannot afford to contribute on a regular basis. Experience in Albania has already shown that non-salaried workers tend to join and contribute to health insurance when they expect to incur substantial expenditures on pharmaceuticals, but not otherwise.
- (ii) In an attempt to ensure the insurance coverage of certain vulnerable groups, many countries with a payroll tax based social health insurance system have created generous categories of insurance beneficiaries that are exempt from making their own contributions, aiming for nominal contributions on their behalf from alternative sources (e.g., pension funds for pensioners, unemployment funds for the unemployed, government budgets), while expecting cross-subsidization from active contributors to those who are exempt. The system has tended to create incentives for a significant share of the population to seek contribution exemptions by, for example, registering as unemployed. In combination with broad based contribution evasion by the active labor force, this has resulted in systems in which a minority of beneficiaries pays for health services consumed by all insurance beneficiaries. This has resulted in the need to keep payroll tax contribution rates high to allow for a minority of contributors to cover costs of the majority of the beneficiaries.
- (iii) Payroll tax contributions for social insurance in Albania are already among the highest in the region (419 percent) and a further increase is likely to push additional workers into the informal sector, which would result in a further decline in insurance coverage. High payroll tax contributions raise the cost of labor and create labor market distortions, thereby hurting the competitiveness of Albanian labor. Proposals to raise the health insurance contribution rate through the reallocation of contribution rates from other insurance funds are not based on thorough actuarial analysis of the potential impact of such a reallocation, and harbor the danger of further throwing those insurance funds into deficit. Furthermore, the administrative, infrastructure, and human resource capacity required to properly build a payroll tax based insurance system are extremely taxing. There is a serious risk that the revenue collection part of the system would divert much-needed efforts and resources of the HII that are required to adequately build up its purchaser capacity. This is the case even if the HII is not directly in charge of revenue collection.
- (iv) Countries which have relied more on general taxation rather than payroll tax contributions have tended to face less steep increases in health care expenditures than those that have relied on contribution based insurance schemes.⁶⁹

⁶⁹ See, for example, OECD, Health Care Systems – Lessons from the Reform Experience, OECD Health Working Paper 3, 2003.

- (v) It is entirely possible to reap the benefits of a single purchaser system without altering the current sources of public funds if budget funds for health are pooled and channelled through the HII as a health care demand rather than as a supply subsidy.

207. **It is recommended that Albania consider shifting to a public health financing system which relies exclusively on general taxation rather than an increase in payroll taxes and a concomitant reduction in general revenue financing.** To streamline the funding system, Albania may want to consider phasing out the payroll tax contribution for health care and replacing it with general revenue financing. Given that non-budgetary social insurance contributions amount to only 7 percent of public sector spending on health care, replacing payroll tax contributions for health insurance with general tax revenues would require an increase in budgetary spending on health care of less than 0.2 percent of GDP. General tax funding could still be channeled through the HII in the form of a generalized contribution subsidy, which would allow HII to purchase certain health services on behalf of the population, thus shifting from the current system that subsidizes the supply of health services to one that subsidizes consumption under well-defined conditions.

208. **A second option would be to maintain the current payroll tax based health insurance contribution in addition to channeling all budgetary funds for personal health care through the HII and creating a two-tiered benefits package.** Government contributions to the HII would then essentially be a first level contribution subsidy, which would compliment the payroll and/or other income based contributions of those who make active contributions. Government payments for well defined low-income groups could be higher than for others, thus making it possible to provide them with the same benefits package as that for those who make their own payroll tax based contributions. General revenue based contributions to HII would then provide for a limited benefits package available to all, which would be supplemented by copayments, while those who have made their own HII contributions and the low income groups would enjoy access to an expanded benefits package that could include access to expanded outpatient drug reimbursement benefits and conceivably lower copayments or expanded benefits. To ensure adequate financial protection of the lowest income groups, the expanded benefits package could be made available from general revenues for the most vulnerable groups (which could be identified through a system of proxy-means indicators). Such a system would prove administratively more burdensome, as it would require that the HII establish and maintain an information infrastructure that tracks the insurance status of all contributors, in addition to building up its capacity on the purchasing side. It might also offer increased room for abuse. Given the currently limited experience and capacity of HII as a purchaser of health services, it may be preferable to focus HII's energy on building up its capacity as an effective purchaser of health services in an administratively less burdensome environment and thus limit public funding to a single source (the general budget).

209. **To ensure greater transparency in the provider system, formal copayments should be introduced for a wider range of health care services, including inpatient care.** The introduction of a wider range of copayments, however, would need to be coupled with efforts to address the issue of informal payments. The objective should not be to increase the overall volume of out-of-pocket payments, which is already high, but to replace, as much as possible, informal payments with formal payments. The development of the copayment system should be linked to the definition of the benefits package that will be made available to the population with public funding (see section G.2). When designing the copayment system, care should be taken to ensure that the system harbors the right incentives for the population to seek care at the adequate provider level, and that the system will not lead to the underutilization of essential and cost-effective care, particularly preventive care. This would mean that preventive health care would largely be excluded from copayments. Protection mechanisms would also need to be put in place to mitigate the impact of the out-of-pocket payments for low-income groups. One possibility might be to exempt the lowest income groups from copayments for a given package of services by giving them a health card, which entitles them to copayment exemptions. Selection could be

based on proxy-means indicators and linked to possible changes in that direction with the targeting of cash social assistance benefits. The high poverty impact of out-of-pocket expenditures for outpatient care suggests that the lowest income groups should be exempt from copayments at the primary care level and also accorded with limited drugs benefits. Furthermore, while the poverty impact from hospital expenditures is lower due to the rare occurrence of hospitalization, hospital expenditures have highly catastrophic proportions for low-income households. Therefore, the benefits package for low-income households should also include limits on copayments for a defined bundle of hospital care for lower income groups. Another option might be to regionally target copayment exemptions for core services (e.g., primary care and limited drugs benefits, maternal and child health services in mountainous regions).

210. **The introduction of formal copayments would need to be linked to efforts to address the issue of informal payments, particularly in the hospital sector**, so as to ensure that copayments would not result in an additional burden on those seeking care. Such efforts might include allowing the provider institution which collects the copayments to allocate at least part of these amounts to improved remuneration of health workers, aggressive information campaigns that would inform the population about the changes, their entitlements and their obligations and the rationale for those measures, introduction of grievance mechanisms for patients and distinct efforts by the provider managers and the HII as their main purchaser to take action upon the receipt of complaints. Finally, a decision would need to be taken on whether copayments will remain the property of the provider or whether they will be returned to the HII. In either case, the provider should be required to account for all revenues and report to the HII on all revenues raised.

G.2. Pooling of Funds

211. **Albania should strive to put all public sector funding for health care in a single pool, with the exception of financing for certain public health interventions provided by the Institute of Public Health and its local affiliates.** The main purpose of pooling health care funds is to increase the redistributive potential of the health financing system to enhance equity in financing and equity in access to services irrespective of the geographical location or socioeconomic status of the individuals in need. The broader the pools are, the easier it will be to rearrange the flow of funds to meet these objectives. It would also make it possible to redistribute funds across types of care or categories of costs. When combined with a single purchaser system, the pooling of funds would also make it possible to structure the purchasing of and payment for health services in a manner that would enhance the efficiency, quality, and transparency of service provision. To guarantee this objective, however, it is important that financing from all sources and for all services be pooled and flow to the provider through the same purchaser. The current system of fragmented payments, particularly for primary care, creates inequities in access as well as in quality of care.

212. **Some proposals that envisage future changes in the system of hospital financing, where HII would finance hospital services for those who are insured while the MOH would continue to finance emergency care for all and capital investments, threaten to have a negative effect on the efficiency of the delivery system.** They would provide incentives to increase the use of emergency services if proof of insurance status was enforced in primary and secondary care and would thus distort the allocation of resources while also undermining the leverage of the HII over providers. A complete separation of funding for investments from funding for operations and maintenance creates little incentive for service providers to effectively maintain equipment and ensure that investments are based on expected utilizations and are thus needs based. While the MOH may in the medium term want to keep control over investment decisions, particularly in the case of hospitals, this does not necessarily mean that funding for all investments should stay outside of the overall provider payment system. What will be required is the development of a clear strategic plan for hospital development in Albania to guide future investment decisions. But once this plan is adopted, and as providers are gradually provided with increased

autonomy in the medium term, a system could be developed in which simple capital investments that fall within the realm of well specified parameters could be left to the discretion of the provider management, while more extensive investments, particularly those pertaining to high end equipment and plant expansion, would require a certificate of needs approved by the MOH.

G.3. Purchasing of Health Services

213. **Effective utilization of limited public sector resources will require that the extent of health services provided from public funding be clearly delineated within the available resource envelope.** Clearly defining the boundaries of what public funds will provide for is important for several reasons: first, it helps improve equity in access to at least a basic package of services; second, it helps to clearly spell out the services for which a health care provider is held accountable under public funding; third, if the information about the patients' entitlements is widely publicized, it can help limit the scope for providers to extract informal payments; and fourth, it helps relate budgets to explicit services rather than inputs. Defining the benefits package requires taking decisions on who will benefit from publicly financed services (breadth of coverage), what services will be financed (depth of coverage), what out-of-pocket contributions beneficiaries will need to make and where and under what conditions services can be accessed. To date, the available benefits package in Albania has not been clearly defined, with the exception of the positive drugs reimbursement list to which HII beneficiaries have access. The challenge for the Government will thus be to introduce financially realistic but socially acceptable limits on the obligations of the public sector to provide for and finance health care, while ensuring that individuals have access at affordable prices to health care services that are appropriate to their medical needs.

Box 5.2 - The Rationale for Purchaser – Provider Split

The rationale for splitting the functions of funding from the functions of providing health care can be summarized in terms of five main objectives. First, services may be improved by linking plans and priorities to resource allocation, for example, shifting resources to more cost-effective interventions and across care boundaries (such as from inpatient to outpatient care). Second, population health needs and consumer expectations may be met by building them into purchasing decisions. Third, providers' performance can be improved by giving purchasers levers such as financial incentives or monitoring tools, which can be used to increase provider responsiveness and efficiency. Fourth, the separation of functions within publicly operated health systems can reduce administrative rigidities generated by hierarchically structured command-and-control models. Management can be decentralized and decision making devolved by allowing providers to focus on efficiently producing the services determined by the purchaser. Finally, the separation of functions can be used to introduce competition or contestability among public as well as private providers and thereby use market mechanisms to increase efficiency.

Source: J. Figueiras, R. Robinson, E. Jakubowski (eds), *Purchasing to Improve Health Systems Performance*, European Observatory to Improve Health Systems and Policies, Oxford University Press, 2005.

214. **The current system of resource allocation, based on historical budgets rather than actual provider utilization, perpetuates inequitable resource allocation and gives providers no incentives to improve efficiency or quality of care.** To help address this issue, the Government's Health Sector Strategy proposes to shift to a system where providers would be paid on the basis of contracts between the HII and providers. As Box 5.2 indicates, separating the functions of financing and provision of health care harbors the potential to improve resource allocation, technical efficiency and quality, and to contain costs. However, these advantages can only be reaped if an appropriate regulatory framework, a good

institutional capacity, and efficient information systems at the purchasing institution and at the provider level are in place. Furthermore, changes in provider payments need to be accompanied by other reforms (e.g., quality improvement efforts) and institutional changes (e.g., changes in provider status and increased facility autonomy) to effect the expected behavioral change (see Box 5.3).

215. **Priority should be given to financing preventive care, affording health protection to the poor, and services, which can yield substantial improvements in health outcomes in a cost-effective manner.** These might be services which would be provided free of charge or against a lower copayment, while others would be provided against a higher copayment or full payment. Definition of the benefits package has proven a politically difficult process in most transition economies, and some countries have chosen to introduce a negative rather than a positive list of services, meaning that they have produced a list of services which are explicitly excluded from state funding. Other countries have defined a positive list based on analysis of high frequency hospital admissions for conditions that could be treated cost effectively at the primary care level or based on interventions which permit the highest health outcome gains among the poor and vulnerable groups.⁷⁰

Box 5.3 - Provider Payment Mechanisms and Behavioral Change

Changes in payment incentives have effected behavior changes, especially if these have been accompanied by other reforms or institutional changes at the provider level. An important adjunct reform has been the education and retraining of providers to improve quality and introduce new protocols. This coordination of reforms can increase impact, even in low-income countries. For example, Uzbekistan began implementation of a new rural primary care model in three pilot regions. The basic elements of the model included formation of new, independent rural physician posts, upgrading of clinical skills and training in general practice, new information systems, pooling of funds for primary care at the regional level, and a new capitated rate payment system driven by consumer choice of physician post. Among other things, the increased autonomy of the providers to allocate their capitation payments led to changes in the cost structure of providers. In one of the three pilot regions for example, the share of provider expenditures devoted to drugs increased by 44 percent from 1999 to 2001. Between 1998 and 2001, average annual visits to primary care providers increased by 224 percent, while referrals from primary care providers decreased by 33 percent.

The need to decentralize management, improve efficiency, and contain costs in the health care system has encouraged the move away from line item budgeting towards performance-based payment mechanisms for inpatient care in many transition countries. Subsequently, payment systems became activity based. Payment was based on measurable units of hospital outputs in the early stages of transition and included per diem and "simple" per case payment not adjusted for patient severity. These models required little data and were relatively easy to implement. Providers responded to these incentives by decreasing the average length of stay. However, any savings to payers were offset by increases in the volume of cases admitted (e.g., Croatia, Czech Republic, Hungary, Russian Federation), especially easy cases that were less costly. In response to cost pressures, many countries have now moved to a form of global budget based on prospective levels of activity and adjusted for severity through some case-mix measure.

Source: Langenbrunner, J.C., Kutzin, J. Wiley, M. Orosz, E. "Rewarding Providers," Chapter 11, in: J. Figueras, R. Robinson and E. Jakubowski (Eds.) *Purchasing Health Services*, Buckingham: Open University Press, 2004.

⁷⁰ Several Latin American countries, including Mexico and Colombia, for example, have defined positive lists for vulnerable groups based on the highest expected health gains. The Slovak Republic has recently defined its positive list benefits package based on an analysis of the main diagnosis of illnesses and treatment protocols. The Kyrgyz Republic defined its reimbursable drugs list based on an analysis of main diagnoses for hospital admissions, which could cost effectively be treated at the primary care level with drug therapy.

216. **To ensure that the proposed systemic changes to provider contracting and payments will have the intended effects on provider efficiency and service quality, the introduction of new funding mechanisms should be carefully planned and combined with efforts to develop managerial capacity, improve information systems, and increase the level of provider autonomy.** Critical steps, which will need to be taken prior to the HII embarking on large scale contracting with providers, include the following:⁷¹

- Taking a decision on the legal status, organization arrangements, governance structures and extent of autonomy for health care providers, and putting in place the necessary regulatory framework to support organizational and governance changes.
- Developing adequate provider reporting and information systems so as to allow for adequate monitoring of provider activity and resource use.
- Developing appropriate provider accounting and financial reporting systems.
- Developing provider accountability mechanisms, including the identification of performance standards, which providers are expected to adhere to and HII will monitor.
- Strengthening provider management capacity and ability to understand and react to incentives in contracts.
- Strengthening HII contracting and contract management capacity.
- Establishing and implementing an adequate physician enrollment program for primary care.
- Developing a medium term strategy and implementation plan for provider payment mechanisms.
- Coordinating provider payment reforms with efforts to improve the quality of care to enhance payment mechanism incentives for behavioral change on the provider as well as the patient side.

217. **Effective utilization of provider contracting also requires that adequate provider payment mechanisms be introduced.** These should give providers sufficient incentives to utilize resources effectively and enhance efficiency, while also allowing them to contain costs. Experience in other transition economies as well as OECD countries suggests that capitation based payments (with possible performance supplements) for primary care and global budgets with case mix adjusters may present a good basis for such changes in Albania. It will, however, be critical that capitation payments (or a variant theory) for primary care include the full cost of providing care (including operating costs and allowance for equipment depreciation) and be based on actual enrollment of patients with a particular doctor or facility. The development of global budgets for hospital providers will need to occur gradually, with the case mix adjusters of gradually increasing complexity evolving as information systems become more developed to provide the necessary data on the financial and clinical performance of facilities and, later, of facility departments.

218. **Albania's experience to date with health finance reforms in Durres and Tirana bring to bear the need to ensure that such reforms are carefully planned and aligned with institutional reforms and efforts to ensure quality improvements.** Albania has experimented with HII and provider contracting in two contexts: the contracting of the HII with Durres Hospital and the contracting for primary care between the HII and TRHA. The Durres pilot has made it possible to develop valuable tools pertaining to information collection and reporting by the provider and has permitted the exchange of information between the provider and the HII. However, it has also pointed to the current systemic

⁷¹ The steps listed below are not exclusive; in particular, if the payroll tax contribution based system is maintained, significant efforts will need to be put into the development of a health insurance beneficiary database and systems, which allow for regular reconciliation of individual contribution payments by the HII.

weaknesses that need to be addressed before the pilot is replicated more widely.⁷² In particular, while the HII currently contracts and pays for services provided by Durres Hospital, the payment system and contract are such that payments continue to be largely unrelated to hospital activity, and therefore the HII is merely a conduit for budgetary resources to the hospital. While the contract in principle is conceived as a global budget, surplus utilization has been subject to year on year negotiation between the HII and the hospital after the fact, thus providing the hospital with little incentive for efficiency improvements. Similarly, only limited additional autonomy has been granted to the hospital's management and even that has not been fully utilized, thus thwarting the potential beneficial effects that such reforms could have on provider performance. Furthermore, in the absence of a clearly defined benefits package, the hospital's contractual obligations with respect to the extent of service delivery have remained blurred. Similarly, the reforms in Tirana region have brought little change overall and have largely failed to improve the quality and responsiveness of primary care providers. This has been due to the fact that the Tirana Health Authority, which is contracted by the HII as the umbrella organization for primary health care in the region, has not been granted any rights to reorganize the provider network and thus to take an active management role, while individual providers have not seen any of their incentives change. As discussed in Chapter 6, the rationale for maintaining a regional health authority at the same time as the HII and for the HII to contract with the health authority rather than with providers directly has also remained unclear. The additional Regional Health Authority layer appears to have brought little benefit, while it may have prevented giving individual primary care providers the direct incentives for client responsiveness and performance improvement. Other planned efforts in Berat, where the HII was to contract directly with individual primary care providers, never got off the ground because of Government inertia and the ensuing failure to decide on the organizational and legal frameworks for primary care providers that were to be contracted.

G.4. Investment Planning

219. As Chapters 2 and 3 have shown, there are substantial variations in the distribution of health care facilities and medical staffs across regions. More detailed analysis of the situation in Tirana carried out by the TRHA further points to gross imbalances in the distribution of facilities and medical personnel even within a region. This points to the need to substantially reshape the provider network. Variations may partly be due to the significant internal and out-migration, which has taken place over the past decade. This not only creates inequities but also leads to ineffective use of scarce resources when medical facilities and staff are underutilized. Currently, investment decisions in the sector are not guided by an overall vision of the sector's structure. This often leads to questionable investments, particularly in the hospital sector. Overall, the needs for investment in the sector remain substantial, as many facilities are in poor condition and lack basic equipment. Therefore, the need to make the most effective use of the country's limited resources for sectoral investments is pressing. As a first step towards ensuring more effective use of resources, the MOH should develop a master plan for the hospital sector, which clearly identifies once and for all which hospitals will be designated regional or multi-regional hospitals, which hospitals will be district hospitals, and which facilities would best be closed or consolidated with facilities close by. Any future investments in the hospital infrastructure should then be guided by this plan.

⁷² See the WHO Organizational Audit on the contractual relationships between the hospital of Durres and the Health Insurance Institute (HII) of Albania, Tirana, March 2005, and METIS Advisory Group, Hospital Sector Management Report, Ministry of Health, August 2004.

G.5. Monitoring of Resource Flow and Sectoral Performance

220. To assess the effectiveness of planned reforms and the overall efficiency with which resources in the sector are utilized, it will be imperative that the MOH and the HII have access to reliable information about health outcomes, the utilization of health care, access to health care, the utilization of human resources, provider performance, and the movement of public and private financial flows in the system. Similarly, it will be increasingly important for providers themselves, particularly their managers, to gain a clear picture of how well their institution performs against established performance indicators and how effectively their resources are utilized. This will become of increasing importance as providers gain increased autonomy. The need for such information, at the policy level, at the level of the purchasing agency and at the level of providers, will require the development of information systems. Management information systems that could integrate clinical, financial, managerial, administrative, and policy-oriented data could give providers more powerful tools for managing care cost effectively and improving its quality. They could give policymakers organized information for evaluating the health system's performance and for designing further improvements. In addition to developing and introducing the relevant information systems, efforts should be made to institutionalize the analysis of sectoral resource flows through the regular updating and refinement of national health accounts.

G.6. Balancing Private and Public Spending in the Health Sector

221. **In the medium to long term, Albania should strive to improve the balance between public and private spending on health care.** Albania spends about 6 percent of GDP on health care. While this is less than most ECA countries spend, it is about on a par with the average for lower middle-income countries. However, the share of public sector spending in Albania (38 percent) is below the average share of lower middle-income countries (38 percent). Over time, Albania should strive to improve the balance between public and private funding. An increase in the share of public funding could be linked to the expansion of the publicly provided benefits package. The high share of private out-of-pocket funding creates serious inequities in access, has a considerable poverty impact, and limits the effectiveness of the Government's sectoral stewardship. However, any increase in public funding should be closely linked to fundamental reforms in the way resources are allocated and utilized.

G.7. Summary and Conclusions

Albania's health financing system is afflicted by several key shortcomings. They include (i) the high share of out-of-pocket spending on care outside an overall financing framework, resulting in the Government's limited ability to properly exercise its stewardship function and creating serious access barriers and financial hardships for low income households; (ii) the inequitable allocation of public sector resources; (iii) fragmentation in public sector financing, resulting in inefficiencies, lack of accountability, and uncertainties; and (iii) provider payment systems which fail to harbor incentives to improve accountability for performance. To address these issues, a considerable change in the health sector financing system is required. This report proposes that the Government introduce substantial changes to the way the health sector is financed. Proposed changes include:

- Pooling all public sector resources under one funding agency (HII), which will contract providers for health services on behalf of the population.
- Relying on general taxation rather than payroll taxes as the main source of public sector financing for health care.
- Clearly defining the benefits which will be made available from public funding.

- Introducing copayments for a wider range of services, including hospital care.
- Introducing copayments for prescription drugs for all beneficiaries.
- Combining introduction of copayments with aggressive efforts to root out informal payments, particularly in hospitals.
- Introducing prospective provider payment mechanisms.
- In the medium term, introducing a better balance between public and private spending on health care.
- Developing a hospital master plan to guide future investments in the hospital sector.

CHAPTER 6: HEALTH SECTOR GOVERNANCE AND ORGANIZATION

A. INTRODUCTION

222. The governance, regulatory and accountability frameworks in the health sector are key elements of the system's overall performance. This chapter will first discuss the legislative and regulatory base of the health sector in Albania, including recent initiatives. The next section will look at the role of the key players in the system and how these roles may need to be changed. It will then review what aspects of sectoral governance may need to be revisited to ensure adequate accountability under a revised system of health care organization.

B. LEGISLATIVE AND REGULATORY BASE

B.1. Key Legislative Acts and Regulations⁷³

223. Albania's Constitution sets out that (i) its citizens enjoy in an equal manner the right to health care from the state, and (ii) everyone has the right to health insurance pursuant to the procedure provided by law.⁷⁴ It thus tasks the state with ensuring equity in access to health care and ensuring financial protection from health shocks. Within the context of discussions on changes in the financial responsibilities of the sector, these constitutional provisions have often been referred to as requiring that the MOH through budgetary funds would pay for all emergency care, while the HII would pay for all other care only for those who are covered by insurance. Within the parameters set out by the Constitution, four key laws currently provide the legislative framework for the health sector; these include the Health Care Act (1963, with subsequent amendments), the Hospital Act (2003), the Law on Health Insurance (1994), and the Law on Medicines (2005).⁷⁵

224. **The Law on Health Care sets out the general framework for the organization and functioning of the health sector.** The most recent amendments to the law date from the mid-1990s and introduced important new concepts, including the concept of mixed public and private health services, the licensing of providers by the MOH, out-of-pocket payment for services stipulated by the Health Care Act, thus canceling the notion of completely free access to care and the principle that foreigners pay for health services unless covered by a bilateral agreement.⁷⁶ These amendments set the stage for important changes in the health system. However, as the Health Care Act is only a framework law, it leaves the

⁷³ This section draws on a report prepared by Igor Tomes for the Ministry of Health, "*Technical Assistance for Drafting Health Financing Legislation In The Republic of Albania, Report 2: Proposals to Enhance Health-Financing Legislation*,".

⁷⁴ Constitution of the Republic of Albania, 1998, Art. 55.

⁷⁵ Act on Health Care: *On Health Care and Free Delivery of Medical Aid by the State*, Law no.3766 (1963), as amended; "*On the hospital care in the Republic of Albania*", Law No. 9106 of 17.7.2003, "*On health insurance in the Republic of Albania*", Law No. 7870 of 13 April 1994, as amended, and "*On Medicaments and the Pharmaceutical Service*", Law No. 9323, Date Nov. 25, 2004.

⁷⁶ The amendments to the Health Care Act stipulate that out-of-pocket payments apply for issuance of health certificates at the individual's request, prosthesis, ambulatory care, and reimbursement of prescription drugs if not referred to/prescribed by a primary care physician, cosmetic interventions, spa treatments, technical-laboratory services or other medical services required by the individual or juridical persons, blood transfusions except if in emergencies, provision of drugs and supplies as stipulated by CoM regulations, and against a 70 percent copayment for adult dental care, and non emergency home visits.

regulation of many critical aspects to the Council of Ministers and the MOH through secondary legislation. Most of this secondary legislation was never passed, while amendments to other legislation (e.g., the Health Insurance Act) ended up being inconsistent with the provisions in the Law on Health Care.

225. **The Hospital Act regulates all aspects of hospital care and hospital management. It allows for the operations of private hospitals and anticipates the licensing of hospitals by the MOH.** It also regulates hospital planning at both the central and regional levels and foresees that hospitals be managed through a regional hospital authority. It envisages that the basis for further development of the (public) hospital sector be a state hospital plan, which would be proposed by the MOH and adopted by the Council of Ministers. The Council of Ministers is called upon to clearly spell out the role and functioning of regional hospital authorities and of the Hospital Planning Commission, the criteria for the opening and closing of hospitals, and the definition of criteria to establish the emergency status of a hospital patient so he would qualify for free care. The MOH is called upon to authorize the opening and order the closure of a hospital, to define criteria for medical services for inpatients and outpatients to be provided by public hospitals, to define the organization, structure and rules of the functioning of the public hospital, and to propose the state hospital plan. As with the Law on Health Care and its amendments, most of the secondary legislation to support implementation of the new legislation was never adopted.

226. **The Law on Health Insurance sets the overall framework for health sector financing by defining the sources of financing and the respective financial responsibilities of various funding agencies.** It also establishes the HII as an independent public institution with an independent budget and sets the stage for compulsory national health insurance financed through payroll tax and other contributions. A 2002 amendment introduced the possibility of voluntary and supplementary insurance, in addition to the mandatory health insurance system, but left implementation to Council of Ministers decisions and MOH regulations. These have not yet been adopted. The amendment also opened the system to wholesale pharmaceutical entrepreneurs, and allowed for the creation of a commission to define the positive list of drugs reimbursable by the HII and the corresponding price list, thereby opening the way for regular price negotiation. Finally, the amendment introduced the obligation to register with the HII and pay contributions and imposed penalties for breach of the law.

227. **The recently adopted Law on Pharmaceuticals provides a sound framework for the operation of the pharmaceutical sector.** The Law was adopted in 2005 and establishes the framework of operation for the private sector, sets the conditions for drug registration and licensing of pharmaceutical providers, and defines the role of the National Center for Drugs Control (NCDC) (see Chapter 4). The Law again calls for a significant number of by-laws, which have not yet been finalized.

228. **Framework legislation to support fundamental changes in the sector has been in place, but the failure to adopt the required secondary legislation has prevented implementation of envisaged changes.** This may be a reflection of the lack of an overall shared vision of the sector's future direction and a sectoral strategy, which could have ensured decisive implementation of the legislation. In the absence of an overall strategy, various legislative acts were often amended in a piecemeal fashion without ensuring overall coherence. A review of the core health sector legal acts carried out by an MOH working group and technical assistance has pointed to inconsistencies across the various acts and the need for a systematic overhaul once a broad based sectoral strategy, including its organizational set-up and financing arrangements has been decided upon and subscribed to by the major stakeholders.⁷⁷

⁷⁷ See Igor Tomes, Final Report 2, *Technical Assistance for Drafting Health Financing Legislation*, Ministry of Health, 2004.

229. **The Government's Health Sector Strategy envisages fundamental organizational and structural changes in the health sector.** The strategy spells out the sectoral vision for the coming years and points to significant changes in the way the sector will be organized and financed, including the following:

- The reorientation of the role of the MOH away from service delivery towards policymaking and sectoral stewardship and the strengthening of its regulatory and oversight capacity
- Increasingly strong reliance on the HII as the key financier for health care services, with the HII contracting directly with providers for service delivery
- The decentralization of service delivery by transforming hospital care providers into autonomous public entities under the governance of hospital boards, while primary care providers would eventually operate as independent providers or groups of independent providers
- The establishment of regional health authorities that would have a planning function and be in charge of managing national public health programs.

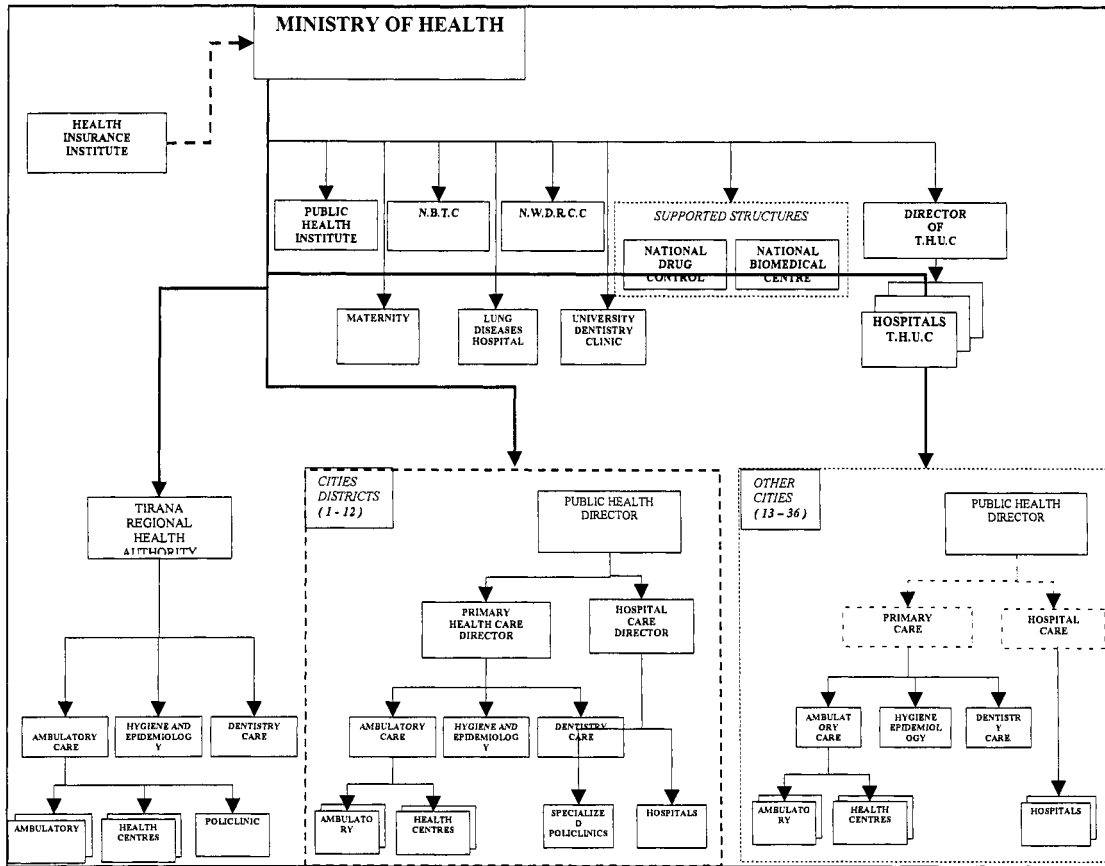
230. **Implementing the strategy will require significant legislative changes, but several aspects pertaining to sectoral organization and financing deserve further clarification prior to proceeding with such changes.** A working group comprised of staff from the MOH and the HII has drafted a new Health Care Act, along with new health finance legislation and amendments to the Hospital Act, but the legislation has not yet been adopted. These draft acts will require further revisions once the details of the system's organizational set-up and financing have been agreed upon. In particular, the sources of public sector funding, the pooling arrangements, the purchasing of services and the role of various institutions, including regional health authorities and individual providers, require further consideration before legislation is finalized and adopted. Beyond the passage of legislation, there needs to be an increased focus on following through with the appropriate regulations necessary to operationalize various acts. It is clear that much more could have been accomplished in terms of health sector reform, even within the boundaries of the existing legislation, had the potential decision-making and regulatory powers been used to the full extent envisioned in the original legislation.

C. THE ROLE OF KEY PLAYERS AND NECESSARY CHANGES

C.1. Organizational Models

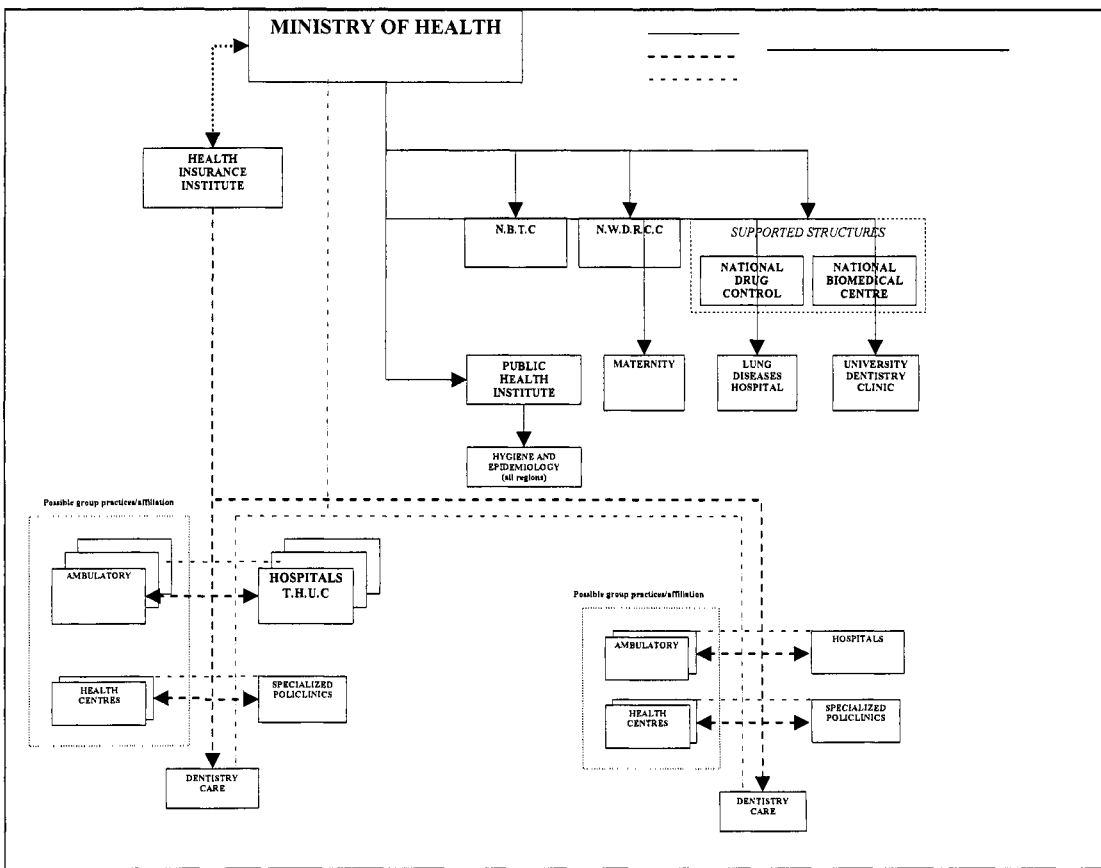
231. **The health sector's current financing and oversight arrangements are complex.** Figure 6.1 provides an overview of the current organizational relationships within the health system in Albania. Financing comes from the HII for primary health care physician salaries, for the TRHA, and for one of the regional hospitals (Durrës). MOH financing is provided for most other services and providers. Non-wage recurrent costs for primary care are funded through the MOH, with payments executed by local governments. The MOH exercises functional oversight for all parts of the health system, concurrent with its line reporting relationships. Outside Tirana, primary care providers report to the regional or district directorate of public health, while hospital providers report to the corresponding hospital directorate. These local directorates in turn report to their corresponding departments in the MOH. As discussed in Chapter 5, the complexity of the arrangements leads to lack of accountability and inefficiencies.

Figure 6.1 - Health System Organization (Current)



232. The system currently piloted in Tirana is a hybrid between a fully regionalized approach and a truly decentralized purchaser-provider model. It retains many of the problems associated with the previous centralized approach and fails to achieve the benefits of the purchaser-provider split. The TRHA was established as a pilot experiment with the objective to consolidate previously dispersed public health and primary health care functions under one umbrella and have TRHA plan and manage these services in Tirana Region so as to optimize regional service delivery. The TRHA experiment is generally regarded as not having met the original expectations for a variety of reasons, including differences in the perceptions of various stakeholders in the key concepts, and indifferent government ownership. While the TRHA advocated keeping all resources in the region under its management and control, the HII continued to advocate the model of direct purchasing between the HII and primary and hospital care providers. Another issue was that the TRHA was in practice granted neither functional nor administrative authority over the health service providers in the Tirana region. Therefore, THRA did not manage to restructure and optimize service delivery in the region. While the TRHA has been contracted by the HII for the provision of primary care, it has not been given the powers to act as the true provider of care. As a result, the costs of an additional administrative layer are maintained while the benefits of regional decentralization and decision-making are not realized. Further, the lines of authority and accountability between the HII, the MOH and the TRHA and front line providers have remained blurred, reducing the overall level of accountability in the health system in the Tirana region. To put the problems experienced with the hybrid system in Tirana in perspective, it is worth reviewing both the fully regionalized model (Figure 6.3) and the decentralized purchaser provider split (Figure 6.2).

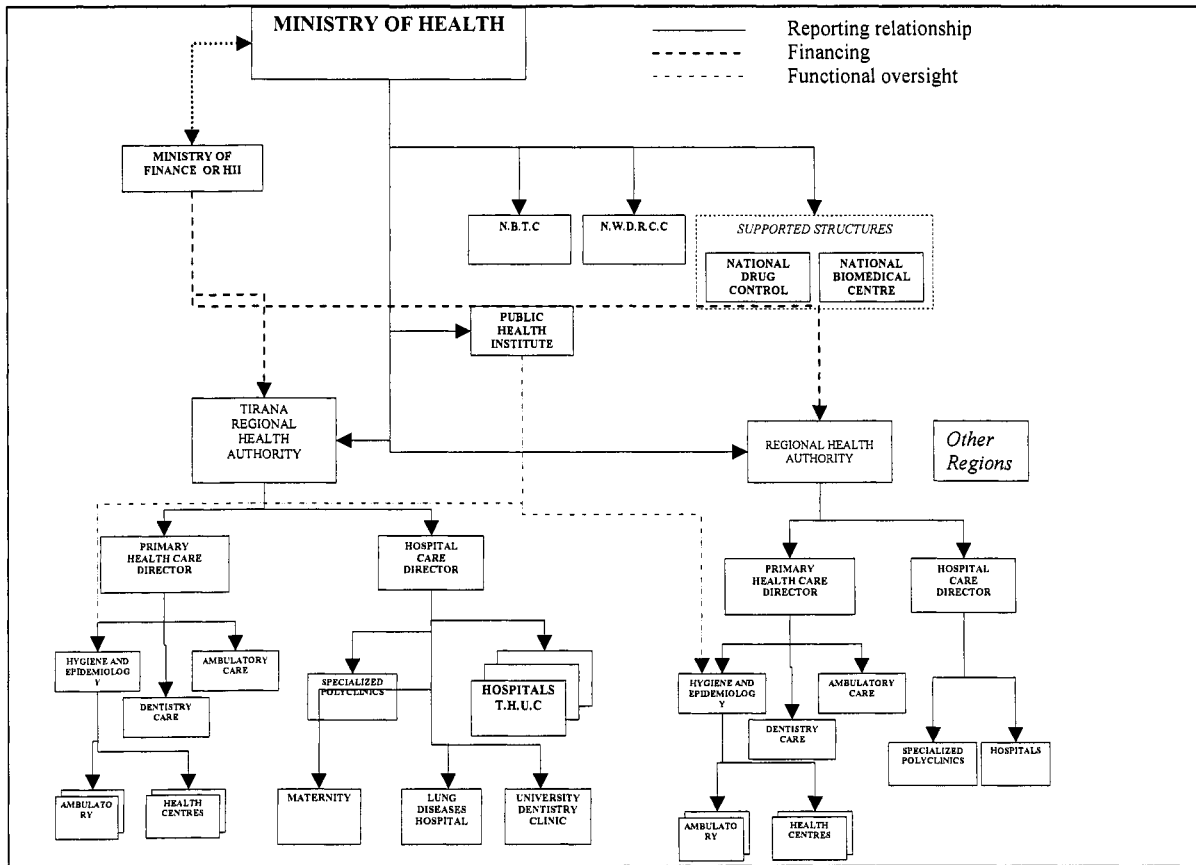
Figure 6.2 - Model A: Purchaser - Provider Model



233. Under a fully decentralized purchaser-provider system, the HII would contract directly with the individual health service providers, thus eliminating the need for a Regional Health Authority. Under this model, individual providers are generally given more autonomy and responsibility than under a regional model. This requires an adequate regulatory framework and governance structures, as well as financing mechanisms and provider contracts which include incentives for providers to produce quality health services at the right level of care and as efficiently as possible. It also requires that the HII establish a capacity to adequately monitor and enforce provider contracts and performance. To reap the model's full benefits, providers would eventually need to be given a substantial amount of managerial and financial autonomy, so as to allow them to adequately react to the incentive structures embodied in the performance contracts. However, such autonomy should only be granted gradually while ensuring that providers (particularly hospitals) have developed the capacity to exercise increased autonomy responsibly. Although this model requires managerial skills at the helm of each provider or group of providers, the level of managerial talent required is less elevated than that in a well functioning RHA model. The purchaser provider split model tends to be a more flexible organizational form and allows individual providers to adjust more promptly to incentives, but it can also lead to fragmentation and lack of continuity of care. Care must therefore be taken to structure purchasing arrangements and contracts in a way that encourages continuity of care and establishes clear patient pathways.

234. Under a fully regionalized approach with Regional Health Authorities, the budget to produce health care in a particular region would be allocated to the RHA which in turn would be in charge of providing all health care in the region and could sub-contract with individual providers. The budgetary allocation could either happen through HII in the form of a contractual arrangement with RHA or, in a situation where essentially all of the public funding comes from general revenues, as in Albania, it could be allocated to RHA directly by the Ministry of Finance based on recommendations from the MOH. The latter would set performance targets and monitor the RHA's achievements. RHA would be responsible for the management of the entire health care system in the region, including all hospitals, and decide upon the allocation of funds across providers. The RHA model has the potential to better ensure full continuum of patient care and facilitate horizontal and vertical integration among providers at the regional level than the purchaser model. However, because of its more hierarchical organizational structure, the RHA model also harbors the danger of becoming more rigid than the purchaser model. This might result in individual service providers having less incentives to produce health care efficiently and effectively.

Figure 6.3 - Model B: Regional Health Authority Structures



Note: In the above model Tirana is shown separately because the TRHA would also cover tertiary care in a fully regionalized model. Other than that the organization would be the same for all regions.

235. **To reap its full benefits, the RHA model requires highly qualified managers.** While the RHA model requires fewer managers than the purchaser model, the skills level and qualifications of RHA managers need to be much higher than those of managers of individual health facilities. The experience in Tirana suggests that the required skills may be difficult to find in Albania, particularly if they are required in each region.

236. **Even in countries with highly developed health care systems and infrastructures, the move to regional authorities has not been easy.** A study of RHAs in Alberta, Canada, concluded: *“Because of limited resources, decision makers must examine how best to allocate health system resources. Health region personnel do not necessarily have the skills to set priorities and make choices about how best to allocate resources.”*⁷⁸ The effectiveness of RHAs stems mainly from their ability to allocate the available funding among service providers in the region and to make the necessary trade-offs to improve overall quality and access to patient care. A recent review of the RHA structures in British Columbia, Canada, concluded: *“They have assumed significant responsibility for the full continuum of patient services and outcomes, as well as accountable fiscal management. Across the spectrum of health care, an unprecedented level of coordination and cooperation has been achieved, allowing for immediate mobilization among care providers when threats to public health emerge.”*⁷⁹ In the absence of the ability to make those trade-offs, it is unlikely that the benefits of the RHA approach outweigh the costs in terms of an additional layer of management and decision-making.

237. **The Health Sector Strategy advocates another hybrid between a direct contracting model and a regional model. It envisages direct contracting between the HII and autonomous providers, with RHAs serving a planning and coordination function** (Figure 6.4). This model was used until recently in Ontario, Canada,⁸⁰ but is currently being replaced with a new approach which also devolves resource allocation to the regional level.⁸¹ It is important to note that the MOH in Ontario is currently serving as the “purchaser” of health services and that there is thus no involvement of an HII. The complexity of the organizational relationships shown in Figure 6.4 compared to the other two options indicates that it would be even more important to specify clearly the relative roles and responsibilities of the various players in the health system – including the MOH, the HII, regional and local authorities, and service providers – prior to further dissemination of a regional authority model. Given the limited institutional and management capacity within the health system, the value and impact of constructing planning-only agencies in addition to the current constellation of health care managers should be carefully assessed.

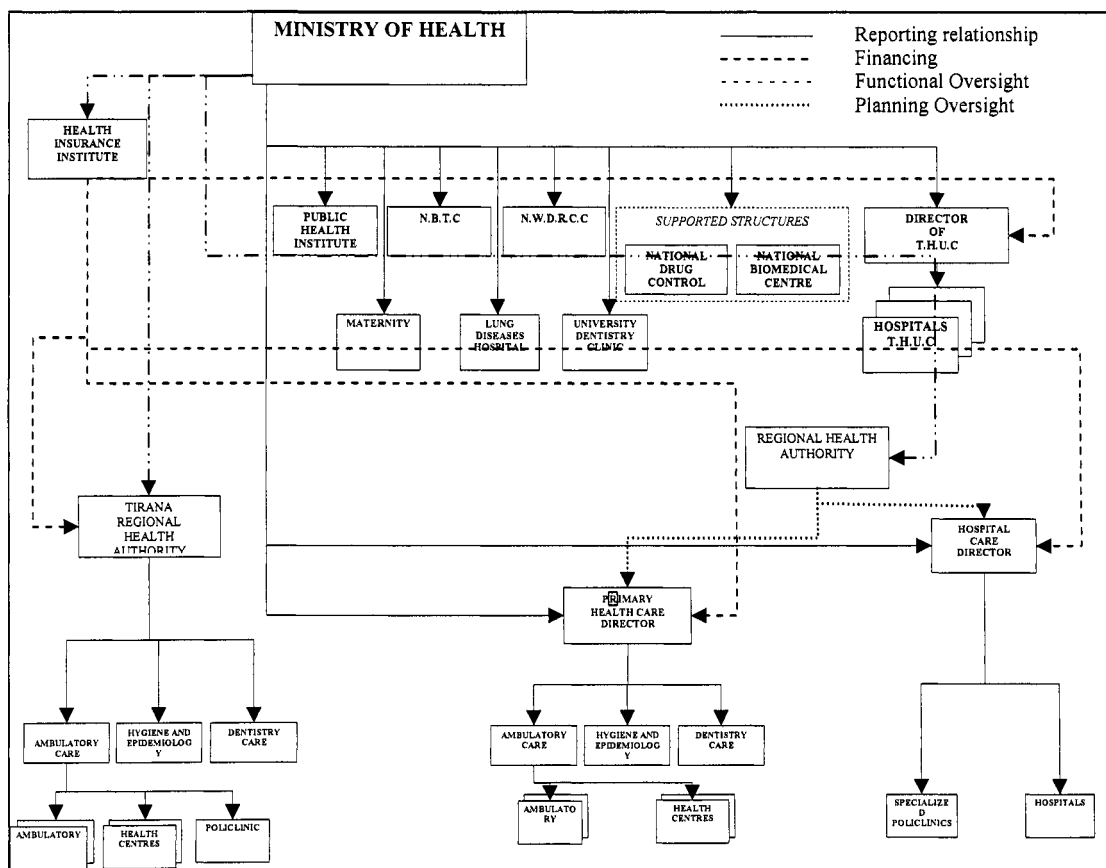
⁷⁸ *Priority Setting within Regional Funding Envelopes: The Use of Program Budgeting and Marginal Analysis*, Donaldson et al., Canadian Health Care Research Foundation, 2001, p. i.

⁷⁹ *Report on Health Authority Performance Agreements 2002/03*, British Columbia Ministry of Health Services, p. 34.

⁸⁰ See: http://www.health.gov.on.ca/english/public/contact/dhc/dhc_mn.html

⁸¹ See: http://www.health.gov.on.ca/transformation/lhin/lhin_mn.html

Figure 6.4 - Model C: Regional Planning and Coordination Structures



238. The merits of expanding regional health authorities should be carefully assessed, based on a thorough evaluation of the TRHA pilot experiment. The TRHA was set up as a pilot and as such has been a valuable experience. However, as every pilot, it deserves careful evaluation to decide what the future should hold for TRHA. It is therefore recommended that the Government commission an independent evaluation of the TRHA experiment as a basis for a decision on whether TRHA should be maintained, its functions and purpose should be restructured or whether it should be dissolved. This is particularly important as Albania's Health Sector Strategy clearly envisages a system where HII would directly contract with individual health care providers or groups of providers. In a small country like Albania, where general revenues constitute the main source of public sector funding for health care and where there are serious constraints on managerial capacity, the establishment of an extra administrative layer in the form of regional health authorities that would co-exist with HII seems of questionable value. The arrangement risks leading to little more than an extra administrative layer which would consume resources that could otherwise be allocated to the direct provision of health care.

C.2. Role of the Ministry of Health

239. Regardless of the organizational option chosen, the MOH needs to move from its current role as the owner and provider of services towards one where it ensures sectoral stewardship. This

would mean that the MOH evolves into a body which sets the overall policy framework, develops system-wide strategies, and provides guidance, oversight, quality monitoring and various central functions to support the overall health system. Although the recent documents of the MOH appear to support this approach, there seems to be a reluctance on the part of various departments in the Ministry to “let go.” The latest draft of the package of laws still gives the MOH considerable operational input into the day-to-day functioning of health care providers. Given the overall level of organizational capacity at the individual provider level at this time, this may not necessarily be inappropriate, but there will need to be a coherent strategy of capacity building to allow this devolution to take place.

C.3. Role of the HII

240. **The future role of HII will depend on the organizational model adopted. HII’s role and responsibility would increase substantially under the direct purchasing model.** The Health Sector Strategy foresees that HII will become the core public sector funding agent for health care. This would require substantial efforts to build the HII’s capacity to act as a true purchaser of health care services rather than a mere conduit for the transfer of public resources to providers. It would also require that the appropriate accountability structures be set up, both for the HII and for providers. Under a direct contracting model, the HII would eventually be contracting with hundreds of individual providers. Under such a system, there would be some merit in encouraging smaller service providers (solo practitioners or small group practices) to affiliate for purchasing purposes and share the costs of practice management and other overheads. A direct contracting system will require HII offices and staff in at least every district, although the majority of the contracts would require relatively simple monitoring systems. The transition to this model would need to be introduced gradually. HII would need to develop its capacity at the central and local levels, while time would also be needed to allow providers to develop their capacity to assume increased managerial responsibilities.

241. **Under an integrated RHA approach, with the bulk of public sector funding coming from general revenues, the need for HII would be debatable.** Public sector funds could be allocated directly to RHA by MoF, based on recommendations and performance targets established by MOH. Alternatively, if funding remains mixed, HII could remain the purchasing agent which contracts with RHA for the delivery of all health care services in the region. However, the costs and benefits of two administrative bodies, HII and RHA, would need to be carefully evaluated, given the small size of the country. There is a considerable risk that the coexistence of HII and RHAs would result in the same situation as in Tirana, with the additional layer of a RHA adding little benefit to the new system.

C.4. Role of Regional Health Authorities and Local Government

242. **The expansion of the integrated RHA approach would result in the health authorities becoming the de facto service provider in each region.** As noted above, this is essential if the benefits of regionalization are to be realized. This expanded role of the RHA would likely result in a diminished role for local governments and the HII, although there is still considerable scope for local input and “voice” in a regionalized system, such as, for example, representation on the RHA board.

243. **Under a direct purchasing approach, the RHA could essentially disappear.** It may be possible to retain the TRHA and/or other RHAs as regional planning bodies, but experience elsewhere has shown that these are of limited use. The role of the local government could expand substantially under a decentralized approach, including in the participation of decision-making with different provider types. For example, there might be local government, regional and/or direct citizen representation on regional hospital boards or local health center boards (see Boxes 6.2 and 6.3 for examples from other countries). These types of initiatives would have to be supported through specific capacity-building measures which would provide essential training in board governance procedures and functions.

C.5. Role of Service Providers

244. **Providers are likely to be most affected by the choice of the organizational approach.** Under the regionalized approach, current service providers would simply change their reporting relationship from the MOH to the RHA. Under the direct purchaser model, on the other hand, they would gradually gain increased autonomy, with primary care providers potentially becoming fully independent providers and hospitals becoming autonomous or semi-autonomous public enterprises or entities.

245. **The legal status and organizational set-up for primary care physicians will need to be revisited.** The Health Sector Strategy foresees that primary care physicians will operate as autonomous individual practitioners or in group practices contracted by the HII. This is the approach which many countries in the ECA region have adopted. In these countries, PHC providers have essentially been privatized and are operating as independent entrepreneurs who have specific contracts with the HII. While this could be a feasible approach in urban areas, the applicability of this model in rural areas deserves further consideration. Alternative options to consider for rural areas might be community based health organizations with which HII would then contract (see Box 6.1) or requiring urban GP groups to also take responsibility for rural areas served by a nurse or midwife under the HII contract. Different organizational models may work for different locations and must be further explored in the Albanian context. Regardless of the final organizational form adopted for primary care, specific training and capacity building in practice management will be needed if the HII is to contract directly with health service providers. Capacity will also need to be developed at the HII level to allow patients to select their primary care physician and to make changes, if desired, at specified intervals.

246. **The Health Sector Strategy foresees that hospital providers will eventually become autonomous public organizations governed by a board,** while the MOH will retain the right to appoint the hospital director. This points to inherent conflict between granting providers increased autonomy under the governance of their boards and MOH's reluctance to withdraw from service delivery. Over time, MOH should completely withdraw from the appointment of managers for hospitals and other health care facilities. Depending in the organizational model chosen, the appointment of hospital directors would become the responsibility of the hospital board or an alternative governing body (see Box 6.3). Under an RHA approach, the health authority director would select key managerial positions for service providers in the region. Managerial autonomy would also entail that provider managers can freely decide on staffing needs and profiles and be given freedom over hiring and firing of hospital staff within established standards.

247. **Changes in the provider payment structure will only be effective if providers are given increased authority over the allocation of resources within a given budget.** This will be a significant change, since with the exception of a few pilot programs, the degree of financial autonomy in the health is system currently very small. However, there are varying degrees of financial autonomy, and clear choices will have to be made by the Government of Albania in setting the boundaries of that autonomy. Some of the issues that will need to be addressed in this area include:⁸² (i) decision rights over labor inputs (hiring, firing, wage levels, performance pay); (ii) decision rights over assets and capital inputs (ownership, disposal, borrowing and for what purposes – capital or operating, certificate of need or other authorization procedures for acquiring/operating certain equipment, depreciation and asset replacement), (iii) decision rights over other inputs such as supplies, pharmaceuticals, etc.; (iv) market exposure (the extent hospitals

⁸² For a more in-depth examination of the issues, see: Martin McKee and Judith Healy (eds.), *Hospitals in a Changing Europe*, European Observatory on Health Care Systems, Open University Press, Buckingham, 2002, pp. 186-194.

are at risk for their performance, whether they lose revenues as they treat fewer patients or, conversely, whether they gain revenues as they treat more patients⁸³; and (v) residual claimant status.⁸⁴

248. **In the medium term, granting hospitals full managerial autonomy, including over decisions of the desired profile, scope of services to be provided and large investments is not advisable in the Albanian context.** Similarly, it is not advisable in the medium term to grant hospitals full financial autonomy to the extent of letting them borrow commercially for investments. On the other hand, as provider management capacity increases, providers should be granted increased autonomy over human and financial resource allocation within a given budget, including staffing positions and salaries, and they should be given the right to decide on the utilization of potential savings achieved under HII contracts. The move to more autonomous hospitals should be a gradual process, with the pace and extent of autonomy provided commensurate with providers' ability to demonstrate capacity and readiness for self-governance by way of reaching gradually rising performance targets.

249. **The move towards increased managerial and financial autonomy of health care providers will require extensive capacity building for staff at all levels of the health system.** This will include training in financial management and control, as well as clear guidelines on the limits and prerogatives related to financial transactions. The autonomy-accountability nexus is particularly important in the financial area and needs to be clearly enunciated through performance contracts, accounting standards and reporting requirements. It also has much wider implications, since it is a major part of the incentive system that directly influences the performance of the health providers in terms of the volume of services provided, the quality of care, and, to a large extent, informal payments (see Chapter 3). The development of these systems of control and accountability is a major undertaking, and must be closely tied to the training needs and activities.

⁸³ Ibid., p. 191.

⁸⁴ Residual claimant status is defined as the degree of financial responsibility, referring to both the ability to keep savings and responsibility for financial losses (debt). The residual claimant status of a hospital is a key incentive to generate savings and efficiency gains.

Box 6.1 - Governance in Primary Health Care

Independent Contractor Model – Bulgaria – Primary care physicians in Bulgaria have the legal status of independent contractors rather than civil servants. All primary care physicians who wish contracts with the NHIF must register as single or group practices, and physicians contract with the National Health Insurance Fund (NHIF). A doctor who does not contract with the Fund may provide services to private patients on a private pay basis. Single and group practices have the right to acquire ownership of premises and medical equipment or to pay low rents to the municipalities for consulting rooms in the former public polyclinics. Alternatively, privately owned premises or rented privately owned offices may be used. Health care is paid for in accordance with the National Framework Contract, which is signed between the NHIF and representatives of the professional organizations of physicians and dentists.

Cooperative Model – Costa Rica – Contracted providers perform their work under the general oversight of the Health Insurance Fund and the Health Ministry (MS) but retain direct governance over their resources and business objectives. The governance of the contracted provider is established wholly by the provider organization. A governing board is established which includes the staff of the cooperative and in some cases members of the community; in the case of the private sector clinics, private management boards have been established; and in the case of the University, a joint University board is established for oversight. The internal organization of the contracted providers is entirely up to the management. Management is named by an administrative council which itself is selected every 2 years by the General Assembly.

Community Co-Management Model – Peru – Health services at the community level are co-managed through a committee of elected community members called CLAS (*Comite Local de Administracion de Salud*). The CLAS administers and manages financial resources transferred from the public treasury for the purposes of providing health services to the community. The CLAS is a private, non-profit entity that is legally registered, composed of three members elected by the community, and three community members selected by the health facility manager. The seventh member is the facility manager, who is usually the chief physician and participates in all decisions of the CLAS and completes the scheme of co-management. Three members form a Board of Directors. All members work on a gratuitous basis for a period of 3 years, after which new members are elected. Members can be replaced before their term is completed due to breach of responsibilities.

Community Board Model – Quebec, Canada – The *Centres Locaux des Services Communautaires* (CLSCs) are the exclusive providers of home care, public health and certain specialized services for individuals, such as programs for children's mental health. Most CLSCs have extended hours (evenings and some weekends) providing an alternative to private walk-in clinics and emergency departments. CLSCs have elected boards comprising members of the community, consumers, medical staff and employees, of the foundation attached to the agency and the executive director of the agency. The Quebec model allows for broad representation and encourages representation from community groups. Because a large number of the board of directors are elected at public Regional Assemblies, strong accountability is inherent in the model.

Box 6.2 - Governance and Organizational Structures in Hospitals

The organizational structure of hospitals is increasingly recognized as a significant determinant of hospital behavior. Previous literature on hospital performance mostly focused on the impact of incentives emanating from the external environment. In particular, payment mechanisms and competitive pressures were much explored. Focusing on external incentives alone, however, assumes that hospital behavior is the result of a rational adaptation process to external determinants. This approach ignores the possibility that the organizational structure of hospitals might mitigate any pressures emerging from the external environment. The behavior of hospitals is determined by the interaction of external incentives and organizational structure. In this framework, hospital behavior is changed positively by introducing complementary and synergetic reforms to both the external environment and the organizational structure of hospitals or hospital networks. Alone, neither is sufficient to change the behavior of organizations. If the external environment does not generate performance pressures, hospitals will have no reason to strive for high performance. However, even with a well-structured external environment, the direction and magnitude of hospital behavioral change might be moderated by the organizational structure of the hospital. Thus, synergistic design between the external environment and the organizational structure of hospitals together create the incentives hospitals face, and hence their alignment is critical to successfully change organizational performance. The following table describes the main governance structures that currently exists in central and eastern Europe:

Country	Governance Status	Director Appointed by:
Croatia	Separate legal entity	Mayor
Estonia	Three types of non-tertiary hospitals (a) municipal not-for-profit (b) joint-stock company (c) trust	(a) Mayor (b) company board (c) trust board
Georgia	Treasury enterprises (self-financing state enterprises) as separate legal entity governed by Law on Enterprises	Minister of Health
Hungary	(a) Separate legal entity that can enter into contractual arrangements, (b) budget unit subject to public finance law	Municipality (assembly or mayor)
Lithuania	Not-for-profit institutions under Law on Health Care Institutions from June 1996	Owning local government
Poland	Budgetary units; legislation passed on 'independent units'	Owning local government
Romania	Extra-budgetary units governed by the Public Finance Law from 1998	District health authority based on MOH criteria

Based on: Martin McKee and Judith Healy (eds.), *Hospitals in a Changing Europe*, European Observatory on Health Care Systems, Open University Press, Buckingham, 2002, pp. 177-186.

C.6. Role of Other Key Stakeholders

250. **In modern health care systems the Institute of Public Health plays a key role in supporting the overall management of the system.** For example, the National Network of Public Health Institutes in the United States defines a Public Health Institute (PHI) as "A PHI is a multi-sector entity able to

*function as a convener to improve health status and foster innovations in health systems,”⁸⁵ while the Finnish Institute of Public Health highlights the following as their key functions: *Research, expert functions, health monitoring, public health services, education and training, international collaboration, development, assessment and performing of laboratory research, and participating in the dissemination of health information and health education.*⁸⁶*

251. **Albania’s Public Health and Health Promotion Strategy envisages an expanded role of the IPH** along these lines, in addition to being responsible for health protection and environmental health. However, to date, IPH has neither been given the full mandate nor the resources to effectively carry out the expanded functions of a modern public health institute. Given the important role that IPH can play in a reformed health sector, including in the collection, analysis and provision of health information to MOH and the public, IPH should be provided with the resources and powers to expand its functions and develop into a modern IPH as outlined in the strategy.

252. **The Medical Association is an important player in a modern health system.** As the roles and reporting relationships of physicians evolve from government employees to independent professionals, new structures will be needed to provide ethical leadership, fulfill registration and licensing functions, and monitor quality and professional standards, including discipline. An effective medical association (order of physicians) can play an important role in establishing and maintaining quality and standards, and through this can perform valuable patient advocacy functions. At the regional and local levels they can also provide useful input to health boards and planning agencies, although care needs to be taken to avoid conflicts of interest. For example, the medical association may be included for technical input only, without having a vote on the final result. However, it must be borne in mind that if adequate governance and control structures are not put into place, such a group can quickly evolve into a trade association or an advocacy group for the medical profession. In many countries two groups are used, with one taking on the “union” roles and the other the professional licensing and monitoring roles. Given the general governance situation in Albania, this may be a preferable approach.

D. STRENGTHENING SECTORAL ACCOUNTABILITY

253. **Albania’s Health Sector Strategy and the reforms proposed here entail substantial changes in the roles and responsibilities of various actors in the sector and will require concerted efforts to strengthen the accountability framework in the sector.** The MOH will assume a policy making and stewardship role and increasingly withdraw from service provision and financing of health care. The HII will assume full responsibility for financing of health care, channeling the Government’s health budget to health care providers by contracting them to offer a defined set of services to the population against an established price. Service providers will be given increased autonomy to decide how to most effectively produce these services and their performance will be evaluated against an established set of performance standards. These changes will require investments in the establishment of new governance structures so as to ensure proper accountability of all actors

254. The World Bank’s World Development Report 2004 uses a three-cornered framework to analyze the accountability relationships between policymakers and service providers; clients and service providers; and clients/citizens and policymakers in a situation where the Government is no longer directly involved in service delivery (see Box 6.1). This framework is utilized here to review the potential

⁸⁵ National Network of Public Health Institutes, <http://www.nnphi.org/what.htm>

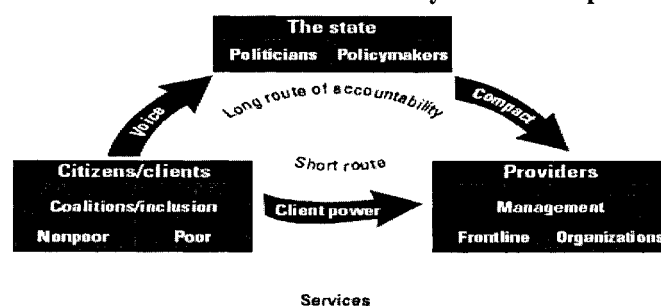
⁸⁶ Finnish Institute of Public Health, <http://www.ktl.fi/portal/english/>

measures that would need to be taken to ensure proper accountability in the envisaged restructured health sector.

Box 6.3 - Service Provider Governance Framework Based on WDR04

The WDR04 governance frameworks encompasses three routes of accountability: the long route, going from citizens to policy makers to providers, where by citizens express their level of satisfaction with service provision through their voice either directly in government or independently sponsored mechanism to seek citizen feedback (e.g. report card system) or indirectly when choosing policy makers through elections. The second part of the long route links the policy makers to the providers through three core mechanisms: (i) the legislative and regulatory framework; (ii) the incentive system and (iii) regular monitoring of provider performance against well established performance targets. The short route of accountability is the one where citizens provide feedback directly to the service providers, most notably by changing their choice of service provider if they are not satisfied with a particular provider. Another dimension of the short route is for citizens to be directly involved in the decision making of service providers through, for example, community representation on provider governance boards or community health boards.

Figure 1: Governance Framework – Key Relationships of Power



Source: World Development Report 2004: Making Services Work for Poor People p. 49

D.1. The Compact Between MOH and Service Providers

255. **Establishing a strong system of provider accountability will be particularly important if providers are granted increased managerial and financial autonomy.** The relationship between the MOH and service providers (the compact) would be defined through three core mechanisms: (i) a revised legislative and regulatory framework establishing the roles, legal status, governance structures, obligations and reporting requirements of all actors involved, (ii) a system of established performance indicators against which the performance of the providers will be monitored and evaluated and, (iii) a system to collect and analyze the data to determine how well providers are performing against the established indicators individually and as a whole. A substantial amount of work will be required in each one of these areas to ensure that a satisfactory accountability system will be in place.

256. **While revisions to the legislative and regulatory framework will be imperative, establishment of performance standards and of a system to monitor and analyze performance will require particular attention.** Both have fallen short of attention to date. Work on performance standards has already been initiated in the hospital sector, but this area will require substantial additional investments and efforts. As indicated in Chapter 2, a key short run priority is the development and

adoption of revised standards in support of an improved licensing system. Performance standards for non-hospital providers, in particularly PHC providers will also need to be developed. Standards need to cover clinical aspects to ensure patient safety, but also physical plant and equipment and managerial and financial operations.

257. **The introduction of a performance monitoring system will require substantial investments in the establishment of a health information system** to provide MOH with the intelligence necessary to appropriately gauge the performance of individual providers and the health system as a whole. This will need to cover all aspects of the health care system, including monitoring of production and delivery of health care by providers, providers' meeting established standards for clinical quality, plant and equipment quality, managerial and financial performance and overall service provision. It will evidently also need to include information on how well the sector is performing on the two ultimate objectives of improving health outcomes and protecting people from health shock induced poverty. Routine information reported by providers, HII and regulatory bodies will need to be complemented by specific surveys to help assess progress against improving equity in access to health care and effects of reforms on households' health seeking behaviors. IPH can play an important role in this area.

D.2. Policy Makers and Citizens

258. **The relationship between policy makers and citizens as a means to strengthen accountability in the health sector has fallen short of attention.** Sectoral stakeholders and citizens need to be given a voice in two respects: first, stakeholders need to be more involved in the formulation of policies and in the decision making process if the envisaged changes are to find broad based support. There is a clear need for MOH to strengthen its outreach efforts and undertake regular public consultation efforts where the objectives and rationale for proposed changes are discussed with stakeholders and their feedback integrated into the design of detailed policy implementation plans. Second, there is a need to seek regular feedback from citizens and local communities about the performance of the health care system. This will be particularly important to assess the impact of proposed changes. In the short and medium run this will require specific efforts to gain such feedback through patient satisfaction surveys, report card systems as they have been introduced by Tirana Municipality, focus group discussions, provider utilization surveys and the establishments of patient complaint mechanisms. In the longer run, more systematic feedback through patient right organizations or similar set-ups might take hold.

259. **MOH should make public information about the performance of the system,** including information about the performance of individual providers in terms of providers meeting or failing to meet established standards, achievement of health outcome targets, utilization of financial resources and corrective action taken by the government against providers who fail to fulfill to meet standards (e.g., withdrawal of license).

260. **Corruption in the health sector is the most visible embodiment of governance failure.** A recent corruption perception survey⁸⁷ notes that bribes (informal payments) in hospitals have the third highest incidence after customs and courts, yet the available data indicate that there are few, if any, prosecutions related to this activity; raising an important question about how to increase the focus and visibility of these problems. Decisive action in this area will be particularly important if formal copayments are introduced for hospital services. The objective of these copayments can not be to increase out-of-pocket expenditures for health care, which are already high, but to replace informal payments with formal payments. To address this issue, a comprehensive approach encompassing the

⁸⁷ *Report on Tri-partite Survey: Civil Society Corruption Reduction Project in Albania*, Management Systems International, Washington, DC, May 2004

following elements will be required: (i) informing the public clearly about their rights and obligations with respect to payment for health care services, including what their entitlements are for free or partially subsidized services and who should provide these, what the price is for services where partial of full copayment applies, who this payment should be made to, who can provide further information in the case of uncertainty and where complaints against violations can be launched; (ii) establishment of a patient grievance system where violators can be identified; (iii) commitment by provider managers to take action against staff who request informal payments; (iv) criminal prosecution of gross violators, (v) explicit provisioning for punitive action for informal payments in the HII-provider contract; (vi) a revision of the remuneration system for health care providers.

D.3. Health Care Providers and Citizens

261. **The relationship between health care providers and citizens can take two dimensions, the population choosing its service provider and the community engaging in supervision of health care providers.** A market based competition is a powerful vehicle for exercise of client power. People chose their service provider and if they are unhappy with the services received move to a different provider. However, the health sector, particularly above primary care, is subject to significant information asymmetries which often make it difficult for care seekers to exercise their voice in an informed manner. Thus, it is primarily at the primary care level where market power can play a role. To a large extent Albanian citizens already exercise this power by circumventing primary care for higher order or private care because of quality concerns at the primary care level. However, this is not an effective mechanism, as it results in higher costs and by extension increased inequity in access to health care. To the extent that primary care providers will be given the support to improve quality of care through skills upgrading and the resources for supplies and equipment, market competition can be introduced by letting the population enroll with the GP of their choice and base physician payment on the number of patients enrolled. While Albanian GPs are currently paid on a capitation basis, this system is not based on an effective enrollment. Thus, as part of the efforts to revise the incentive framework for health care providers, an enrollment based GP payment system may prove to be an effective mechanism to let citizens provide feedback to providers on their performance in areas where citizens indeed have a choice (e.g., where there are multiple providers). In other areas, alternative mechanisms will need to be sought. One possibility is the involvement of local communities in community health organizations which supervise the performance of the provider, another one is the representation of communities on the board of providers.

E. CONCLUSIONS AND RECOMMENDATIONS

262. This chapter has sought to cover a large and often ignored aspect of the health system – the regulatory, governance and organizational framework – and has attempted to relate these to the health reform strategy that is currently being pursued. It is clear from the reform process in many other countries that these issues are often ignored or inadequately addressed, which results in the failure of many sound technical approaches to be implemented correctly or completely.

263. Compounding the importance of these areas are (i) the fact that it is not possible for the system or its managers to start afresh, and (ii) the reality that it is not prudent or feasible to put off all changes until appropriate capacity building, regulatory and structural organizational and governance changes have been put into place. Establishing the appropriate pace of all of these activities, so that even small changes are mutually reinforcing, will be a significant challenge. However, a sound implementation plan will have to accomplish just that.

264. Before the legislative packages are finalized it will be critical to carefully examine the organizational structures of the health system to ensure that there are no inconsistencies or paradoxes

between the stated objectives of the reform effort and the structures established to move that effort along. Specific areas that need to be examined, in consultation with all of the relevant stakeholders, include the following:

- Commission an external evaluation of the TRHA pilot and deciding whether TRHA should continue to exist in its current format, whether it should be restructured and its mandate revisited or whether it should be abolished.
- Deciding on the future organizational and managerial set-up in the health sector outside Tirana region in light of TRHA pilot evaluation and Government's stated strategy to shift to a direct purchaser model.
- Deciding on the desired role of local government in the planning and governance of health care providers.
- Deciding on the organizational and governance structures for primary and hospital care providers.
- Developing the regulatory framework which supports the aspired organizational model.
- Developing a system of performance standards to gauge performance of individual providers and the sector as a whole.
- Establishing a system of regular performance monitoring and develop health information system to support it.
- Establishing mechanisms to seek regular feedback on provider and sectoral performance from citizens.

Annex 6.1 – Models of Primary Health Care Organization and Financing

Independent Contractor Model – Bulgaria⁸⁸

Primary care physicians in Bulgaria have the legal status of independent contractors rather than civil servants. All primary care physicians who wish contracts with the NHIF must register as single or group practices, and physicians must contract with the National Health Insurance Fund (NHIF). Some group practices employ a practice manager to handle financial affairs, logistics and interactions with the NHIF. A doctor who does not contract with the Fund may provide services to private patients on a private pay basis. Most existing polyclinics have been transformed into diagnostic and consultation centers or medical centers and registered as trade companies. These new organizational forms are housed in the buildings of former polyclinics, owned by the municipalities. Single and group practices have the right to acquire ownership of premises and medical equipment or to pay low rents to the municipalities for consulting rooms in the former public polyclinics. Alternatively, privately owned premises or rented privately owned offices may be used.

Health care is paid for in accordance with the National Framework Contract, which is signed between the NHIF and representatives of the professional organizations of physicians and dentists. At the beginning of July 2000, contracts signed with the NHIF filled 98.4 percent of the primary care positions specified by the National Health Map. Patients are given free choice of a primary care physician (general practitioner), but must register with a particular GP. General practitioners act as gatekeepers to the system, with visits to specialists requiring referral from the primary care physician.

The basic package for primary health care contains the following services:

- ambulatory care (examination)
- surveillance, home visits, consultations
- health promotion and health prophylactics
- immunizations
- referrals for medical and diagnostic tests
- prescription of drugs, etc.

For the performance of services included in the basic package, general practitioners are paid by capitation on the basis of the number of patients on their list. In addition to the basic package of services general practitioners participate in a special health program, called Management of Health Priorities, including:

- maternal and infant health care
- adolescent health care
- health care for chronic diseases (diabetes, cardiovascular diseases, etc.)
- care for elderly persons
- health care for terminally ill.

These activities are not obligatory for a general practitioner, but additional remuneration for performing these interventions encourages general practitioners to provide such additional preventive and other services. Extra remuneration is paid to general practitioners working in practices under unfavorable conditions, such as regions with poor infrastructure, remote or mountainous areas.

⁸⁸ Adapted from *Health Care Systems in Transition: Bulgaria*, The European Observatory on Health Care Systems, 2003.

Cooperative Model – Costa Rica⁸⁹

The main objective of the cooperative model is to generate the best possible social well-being of an assigned population with the existing resources.

Regulation: Contracted providers perform their work under the general oversight of the CCSS [Health Insurance Fund] and the Health Ministry (MS) but retain direct governance over their resources and business objectives. Service agreements contain three key elements:

- The population to be covered and the types of services to be delivered, including established protocols and guidelines which outline the purchaser's expectations.
- Performance indicators covering (i) provision, including coverage rates and compliance with protocols; (ii) quality indicators related to technical and perceived quality of services; (iii) organization of the services, management capacity and its role in managing patients and resources; and (iii) billing including the providers role in documenting the cost and volume of services provided.
- A system for monitoring and evaluation which outlines not only the procedures but also the process by which the providers will be evaluated.

Governance: The governance of the contracted provider is established wholly by the provider organization. In the case of cooperatives a governing board is established which includes the staff of the cooperative and in some cases members of the community; in the case of the private sector clinics, private management boards have been established; and in the case of the University, a joint University board is established for oversight.

Financing: The financing function has been fully retained by the CCSS, which is responsible for financing 100 percent of the health care services through payroll contributions and government transfers for the uninsured. The financing of the contracting model retains public financing and no additional fees are charged by the providers.

Organization. The internal organization of the contracted providers is entirely up to the management. In the case of the cooperatives, management is named by an administrative council which itself is selected every 2 years by the General Assembly. The model is guided by Law 4179 of cooperative associations and their reforms. The most important aspect of this kind of organization is the contribution by all associates to the social capital of the company. Periodically, associates receive a share of the profits generated by the cooperative.

Community Co-Management Model – Peru⁹⁰

Health services at the community level are co-managed through a committee of elected community members called CLAS (*Comite Local de Administracion de Salud*). The CLAS administers and manages financial resources transferred from the public treasury for the purposes of providing health services to the community. The CLAS is a private, non-profit entity that is legally registered, composed to three members elected by the community, and three community members selected by the health facility manager. The seventh member is the facility manager, who is usually the chief physician and participates in all decisions of the CLAS and completes the scheme of co-management. Three members form a Board

⁸⁹ Adapted from: *Health System Innovations in Central America, Contracting Primary Health Care Services: The Case of Costa Rica*, Cercone et al., September 2004, pp. 8-9.

⁹⁰ Adapted from *Health Reform, Community Participation, and Social Inclusion: The Shared Administration Program*, UNICEF Peru, August, 1998, and *The Challenge of Health Reform: Reaching the Poor*, Europe and the Americas Forum on Health Sector Reform, San Jose, Costa Rica, May, 2000.

of Directors. All members work on a gratuitous basis for a period of 3 years, after which new members are elected. Members can be replaced before their term is completed due to breach of responsibilities.

Two types of contracts exist between the CLAS and MOH: a Shared Administration Agreement (covering infrastructure, equipment, medicines and personnel posts) which lasts 3 years, and an annual Management Contract for the provision of health services. CLAS is held accountable for ensuring implementation of the local health program that is developed annually on the basis of the community health diagnosis. CLAS is given the power to contract health personnel and other workers of the health facility, and make decisions on how funds are utilized.

An alternative organizational form is the “aggregate CLAS,” where multiple facilities (an ideal number of five or six is mentioned), are incorporated into a single network administered by a single CLAS. Each facility has a local health plan, which is joined into an aggregate plan to serve as the basis for the Management Contract.

Community Board Model – Quebec, Canada

The *Centres locaux des services communautaire* (CLSCs) are the exclusive providers of home care, public health and certain specialized services for individuals, such as programs for children’s mental health. Most CLSCs have extended hours (evenings and some weekends) providing an alternative to private walk-in clinics and emergency departments. The CLSCs also have elected boards comprising members of the community, consumers, medical staff and employees, of the foundation attached to the agency and the executive director of the agency. The Quebec model allows for broad representation and encourages representation from community groups. Because a large number of the board of directors are elected at public Regional Assemblies, there is a strong accountability feature built in.

CHAPTER 7: CONCLUSIONS – IMPLEMENTATION OF HEALTH SECTOR REFORMS

265. **The changes in the organization, financing and delivery of health care proposed here, and also largely subscribed to in the Government’s Health Sector Strategy, will require a gradual introduction and careful preparation.** Timing and sequencing of reforms are critically important to allow the health system to prepare itself to absorb the changes and to ensure that capacity at all levels is established to reap the benefits of the intended changes. Substantial efforts in capacity building of health care providers, HII, and MOH will be required to ensure that all actors are ready to assume their increased responsibilities. Fundamental decisions on the legal status, organizational arrangements, governance structures, and extent of autonomy for health care providers will need to be taken before such changes can be introduced. Provider accounting systems need to be strengthened, performance standards established and adequate provider reporting and information systems introduced to allow for appropriate performance monitoring and transparency. Provider management capacity will need to be developed and payment reforms will need to be coordinated with efforts to improve the quality of care to enhance payment mechanisms’ incentives for behavioral change on the provider as well as the patients’ side.

266. **Therefore, it is proposed that the Government consider implementing reforms in a phased approach.** The first phase consists of a preparatory phase, which involves deciding on provider organization and governance structures, developing appropriate accountability and reporting mechanisms, developing and costing out the benefits package to be made available from public funding, enhancing the legislative framework to support the changes, and establishing training programs in provider management and clinical skills upgrading, with initial emphasis on primary care providers. The second phase would gradually introduce changes in provider organization and financing in parallel with upgrading of clinical and managerial skills. Building on work already undertaken with the support of USAID financing, the emphasis during the second phase would be on supporting the gradual roll out of changes at the primary care level, while piloting proposed managerial and financing changes in a limited number of hospitals only. It is proposed that the roll out of reforms during phase two be undertaken gradually. Initially in two regions, then in a limited number of additional regions and, by the end of phase two, to all regions. During a third phase, reforms would be further consolidated and expanded to cover the rest of hospital providers. In parallel, during the first and second phase the capacity of IPH to assume increased responsibilities in health promotion, health information and health intelligence, and new public health initiatives would be strengthened to ensure that it can assume these important new functions effectively. The table below summarizes proposed actions in this phased framework.

Table 7.1 - Proposed Phasing of Health Sector Reforms

Objectives and Programs	Phase 1: One year preparatory phase	Phase 2: Three to four years following completion of phase 1	Phase 3: Three to five years following completion of phase 2
Establish institutional framework to support reforms	<p>Evaluate TRHA experience and decide on sectoral organization, clearly define role and responsibilities of all key actors</p> <p>Decide on organizational set-up, legal status, and governance structure of primary care providers in urban and rural settings</p> <p>Decide on legal status and governance structure of hospital providers</p> <p>Establish legal basis for revised organizational set-up, including revised legal status of providers</p>	<p>Initiate implementation of revised sectoral governance system</p> <p>Registration of PHC providers as independent legal entities allowed to contract with HII</p> <p>Registration of pilot hospitals as independent legal entities allowed to contract with HII</p>	Registration of all remaining hospitals as independent legal entities allowed to contract with HII
Introduce single payer health finance system	<p>Decide whether HII payroll tax contribution should be replaced with general revenue financing</p> <p>Establish legal basis for revised health finance system, allowing for pooling of all public funding under a single payer and direct contracting of providers with HII</p> <p>Determine scope of services covered from public resources, in line with available resource envelope, determine content and cost structure of package of services to</p>	<p>Set up unified database of all HII beneficiaries and register population with primary care physician, staged region based roll out</p> <p>Introduce revised PHC provider accounting and activity information systems, staged region based roll out</p> <p>Train PHC providers in practice management, stage region based coverage</p> <p>Evaluate Durres-HII pilot and define revised prospective hospital</p>	<p>Gradual expansion of HII contracting to remaining hospitals</p> <p>Generalized introduction of revised hospital accounting, reporting, and information system</p> <p>Generalized introduction of revised copayment system at hospital level and system to eradicate informal payments</p>

Objectives and Programs	Phase 1: One year preparatory phase	Phase 2: Three to four years following completion of phase 1	Phase 3: Three to five years following completion of phase 2
	<p>be delivered by PHC providers to be contracted by HII</p> <p>Finalize design of revised PHC provider accounting and reporting system and of primary care information system to support direct contracting with HII</p> <p>Determine PHC provider payment mechanisms, draft contracts and monitoring indicators</p>	<p>payments system to be piloted in additional 3 hospitals</p> <p>Develop revised hospital accounting system</p> <p>Develop and pilot test revised hospital financial, activity and reporting system</p> <p>Strengthen HII information system, including provider interface</p> <p>Pilot HII contracting with hospitals in 3 additional hospitals (2nd half of phase 2)</p> <p>Train HII staff in all aspects of health insurance management</p> <p>Establish population risk adjusted formula for regional allocation of HII resources</p> <p>Adopt scope of services to be provided with public funding and complete computation of unit costs of covered services</p> <p>Gradually introduce revised copayment policy, including for inpatient care</p> <p>Implement public information campaign informing population of rights and obligations</p>	

Objectives and Programs	Phase 1: One year preparatory phase	Phase 2: Three to four years following completion of phase 1	Phase 3: Three to five years following completion of phase 2
		<p>under new scope of service provision and copayments policy</p> <p>In parallel to introduction of revised copayments policy, launch no tolerance for informal payments campaign including establishment of patient grievance system</p>	
Strengthen quality and effectiveness of primary care	<p>Continue development of clinical practice guidelines and establish system of continuous medical education</p> <p>Establish center for continuous medical education and develop initial retraining courses with focus on training on initial set of clinical guidelines</p> <p>Initiate preparation of regional PHC plans based on existing and expected utilization and aspired efficiency targets to guide any future investments in PHC</p>	<p>Complete core PHC clinical practice guidelines</p> <p>Initiate continuous medical education system and train PHC providers in utilization of initial set of clinical practice guidelines and rational prescribing, staged regional roll out</p> <p>Complete regional PHC plans and utilize as basis for future investments in PHC</p>	Expand depth and coverage of continuous medical education for PHC providers
Hospital sector reorganization	Complete hospital network master plan as basis for all future investments in hospital sector	<p>Launch implementation of hospital network master plan, including consolidation and/or conversion of small hospitals</p> <p>Determine role, composition, rights, and responsibilities of hospital boards and hospital managers for pilot hospitals to be contracted by HII.</p>	<p>Continue implementation of hospital network master plan</p> <p>Based on experience with pilot hospitals, gradually expand limited autonomy to remaining hospitals, based on individual hospitals meeting</p>

Objectives and Programs	Phase 1: One year preparatory phase	Phase 2: Three to four years following completion of phase 1	Phase 3: Three to five years following completion of phase 2
		<p>Establish performance criteria for various stages of hospital autonomy</p> <p>Establish hospital management training program for managers and board members of pilot hospitals</p>	<p>autonomy readiness milestones</p> <p>Expand coverage of hospital management program</p>
<p>Strengthen regulatory framework and quality assurance system</p>	<p>Establish legal basis for revised physician and facilities licensing system requiring regular relicensing</p> <p>Establish independent quality assurance group to set provider quality standards</p> <p>Decide on institutional set up to monitor and enforce standards and establish corresponding legal basis</p> <p>Determine body to adopt clinical practice guidelines, review completed hospital guidelines, and proceed to adoption of revision</p>	<p>Introduce revised, time bound physician and facilities licensing system, with objective of having first PHC physician cohort gone through relicensing by end of phase 2</p> <p>Develop and adopt provider standards for clinical care, physical plant and equipment in hospitals and outpatient setting</p> <p>Set up and implement system to survey provider performance against standards</p> <p>Set up and implement system to assist hospital providers with development of quality improvement plans to move towards meeting standards within agreed timeframe</p>	<p>Expand coverage of continuous medical education system to hospital physicians</p> <p>Continue implementation of physician licensing and relicensing system to cover all physicians by end of reform program</p> <p>Continue development and regular updating of quality assurance and control guidelines</p> <p>Regular assessment of all providers against established standards and against progress under adopted quality improvement plans</p> <p>Revise and update hospital treatment guidelines</p>
<p>Epidemiological surveillance and health information</p>	<p>Determine roles and responsibilities of IPH and MOH Policy and Planning Unit in the area of health information collection and analysis</p>	<p>Design and establish system to monitor and evaluate impact of reforms at provider and health care consumer level, based on baseline</p>	<p>Continue practice of regular performance reviews and performance monitoring</p>

Objectives and Programs	Phase 1: One year preparatory phase	Phase 2: Three to four years following completion of phase 1	Phase 3: Three to five years following completion of phase 2
		<p>and regular follow-up surveys and provider activity and financial reporting system</p> <p>Institute system of annual sector performance review with key stakeholders</p> <p>Standardize reporting of mortality and diseases to allow for tracking and time trend analysis</p> <p>Establish protocols and case definitions of reportable mortality and morbidity information</p> <p>Train providers in reporting system and strengthen IPH investigative capacity</p> <p>Strengthen HIV/AIDS surveillance capacity</p>	<p>Further Strengthen analysis of health information and surveillance capacity</p> <p>Further develop surveillance system capacity at provider level</p>
Strengthen capacity for public health and health promotion	Ensure appropriate budgetary allocations to initiate implementation of public health and health promotion strategy	Implement public health and health promotion strategy, revise and update as necessary	Continue implementation of public health and health promotion strategy, revise and update as necessary
Enhance pharmaceutical sector stewardship and cost containment strategies	<p>Clarify status and role of NCDC and adopt relevant subsidiary legislation</p> <p>Define and adopt transparent criteria for selection of commission members, standard operating procedures, decision making process, and reporting requirements of commissions for registration,</p>	<p>Strengthen NCDC capacity to sample drugs for quality checks and contract with an international laboratory for sample analysis</p> <p>Establish public information system to inform public about outcomes of quality controls.</p> <p>Introduce external</p>	<p>Regular review of pharmaceutical expenditure trends and introduction of corrective measures as required</p> <p>Generalized introduction of improved hospital drugs management system</p>

Objectives and Programs	Phase 1: One year preparatory phase	Phase 2: Three to four years following completion of phase 1	Phase 3: Three to five years following completion of phase 2
	<p>reimbursement and licensing</p> <p>Revise positive list of drugs to be more restrictive and based on cost-effectiveness considerations, institute requirement that any revision of positive list must be accompanied by fiscal impact and cost-effectiveness evaluation</p> <p>Introduce revised copayment system for all prescription drugs, eliminating non-income targeted copayment exemptions</p> <p>Revise reimbursement system to limit reimbursement to lowest cost alternative for an indication based reference group</p>	<p>reference price system for single source drugs</p> <p>Further revise wholesale and retail drugs margin system, based on potential fiscal impact evaluation of flat fee per prescription of dispensed drug or lower overall margin without wholesale and retail specifications</p> <p>Adopt legislation making adoption of EFPIA guidelines for marketing of drugs a prerequisite for licensing of manufacturers and importers</p> <p>Develop improved hospital drugs management procedures</p>	
Enhance sectoral human resource management		<p>Strengthen the human resource management information system at the MOH and use information for resource planning</p> <p>Establish inter-agency HR working group to address core health sector HR issues beyond scope of MOH</p> <p>Define a human resource strategy for the health sector taking into account changes in provider autonomy and synergies</p>	<p>Implement the human resource strategy</p> <p>Implement salary reform that awards quality of care and sets incentives to increase productivity</p>

Objectives and Programs	Phase 1: One year preparatory phase	Phase 2: Three to four years following completion of phase 1	Phase 3: Three to five years following completion of phase 2
		<p>from the private sector</p> <p>Define a strategy to reform the current provider salary mechanisms by paying providers based on their performance</p>	

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