European Observatory on Health Care Systems

Health Care Systems in Transition

Albania



The European Observatory on Health Care Systems is a partnership between the World Health Organization Regional Office for Europe, the Government of Norway, the Government of Spain, the European Investment Bank, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine

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By the year 2005, all Member States should have health research, information and communication systems that better support the acquisition, effective utilization, and dissemination of knowledge to support health for all.
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Contents

Foreword

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

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

The aim of the HiT initiative is to provide relevant comparative information to support policy-makers and analysts in the development of health care systems and reforms in the countries of Europe and beyond. The HiT profiles are building blocks that can be used to:

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

The HiT profiles are produced by country experts in collaboration with the research directors and staff of the European Observatory on Health Care Systems. In order to maximize comparability between countries, a standard template and questionnaire have been used. These provide detailed guidelines

and specific questions, definitions and examples to assist in the process of developing a HiT. Quantitative data on health services are based on a number of different sources in particular the WHO Regional Office for Europe health for all database, Organisation for Economic Cooperation and Development (OECD) Health Data and the World Bank.

Compiling the HiT profiles poses a number of methodological problems. In many countries, there is relatively little information available on the health care system and the impact of reforms. Most of the information in the HiTs is based on material submitted by individual experts in the respective countries, which is externally reviewed by experts in the field. Nonetheless, some statements and judgements may be coloured by personal interpretation. In addition, the absence of a single agreed terminology to cover the wide diversity of systems in the European Region means that variations in understanding and interpretation may occur. A set of common definitions has been developed in an attempt to overcome this, but some discrepancies may persist. These problems are inherent in any attempt to study health care systems on a comparative basis.

The HiT profiles provide a source of descriptive, up-to-date and comparative information on health care systems, which it is hoped will enable policy-makers to learn from key experiences relevant to their own national situation. They also constitute a comprehensive information source on which to base more in-depth comparative analysis of reforms. This series is an ongoing initiative. It is being extended to cover all the countries of Europe and material will be updated at regular intervals, allowing reforms to be monitored in the longer term. HiTs are also available on the Observatory's website at http://www.observatory.dk.

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

The European Observatory on Health Care Systems is a partnership between the WHO Regional Office for Europe, the Government of Norway, the Government of Spain, the European Investment Bank, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine.

The Observatory team working on the HiT profiles is led by Josep Figueras, head of the secretariat and the research directors Martin McKee, Elias Mossialos and Richard Saltman. Technical coordination is by Suszy Lessof. The series editors are Anna Dixon, Judith Healy and Elizabeth Kerr.

The research director for the Albania HiT was Martin McKee.

Administrative support, design and production of the HiTs has been undertaken by a team led by Phyllis Dahl and comprising Myriam Andersen, Sue Gammerman and Anna Maresso. Special thanks are extended to WHO Regional Office for Europe health for all database from which data on health services were extracted; to the OECD for the data on health services in western Europe, and to the World Bank for the data on health expenditure in central and eastern European (CEE) countries. Thanks are also due to national statistical offices that have provided national data.

Introduction and historical background

Introductory overview

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

Albania has a younger population than other European countries. One third of its population of 3.2 million are under the age of 15, and 40% are under the age of 18 years (Table 1). The population grew by 1.5% in 1994 with a fertility rate of 2.7 children per woman of childbearing age *(23)*. The country experienced even higher population growth in earlier decades, encouraged by the pro-natalist policy of the previous communist regime.

Albania has a high proportion of its population living in rural areas, amounting to just under two thirds in 1993. However, since restrictions on movement were lifted in the 1990s there has been unprecedented internal migration from rural to urban areas. Given this rapid influx, the exact population of Tirana is unknown but is estimated to be over 450 000, which has put considerable strain on the city's infrastructure and health services *(11)*.

Many people also have left the country – over 300 000 between 1990 and 1995 *(9)*. Many thousands of Albanians crossed the Strait of Otranto, although the rate of emigration may have slowed since Italy no longer accepts people deemed to be economic refugees. On the other hand, in early 1999 there was a large scale migration of over 750 000 people from Kosovo. As a result, over 400 000 people sought temporary refuge in Albania.

About 97% of the Albanian population are ethnic Albanians, 1.9% are Greeks, and other groups are represented in small numbers. A unified form of the Albanian language has been used since the early 1970s. Islam is the religion

of 70% of the population, 20% are Orthodox Christian and 10% are Roman Catholic *(14)*. These figures reflect 'the religion of origin' since religion has not been an important identity element in Albanian society. However, with the return of religious freedom many mosques and churches, which were closed in 1967, have now reopened.

Fig. 1. Map of Albania[1]

Source: Central Intelligence Agency, The World Factbook, 1997.

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

Table 1. Demographic indicators

Indicators	1990	1991	1992	1993	1994	1995	1996	1997
Population (millions)[a]	3.273	3.259	3.189	3.154	3.178	3.219	3.263	3.324[b]
% population under 18 years (a)	38.5	38.8	39.6	40.2	40.3	40.1	39.6	–
Ratio of births to deaths[a]	19.5	18.3	13.0	8.4	–	–	–	–
Live births per 1000 population[a]	25.2	23.4	23.6	19.2	23.1	22.2[b]	20.8[b]	18.6[b]
Deaths per 1000 population[a]	5.6	5.4	5.9	6.3	5.5	5.6	5.7	5.5[b]

Source: [a] UNICEF TransMONEE database 3.0 [b] Statistics Department, Ministry of Health.

The ancestors of the Albanians, the Illyrians, preserved their own language and culture despite the establishment of Greek colonies in the seventh century BC, later followed by centuries of Roman rule. Illyria became part of the Empire of Byzantium in the division of 395 AD. Migrating Slavic and Germanic groups invaded the region throughout the fifth and sixth centuries so that ethnic Illyrians survived only in the south. Control of the region was contested by various neighbours, and in 1344 the country was annexed by Serbia, which in turn was occupied by the Turks in 1389. A national Albanian hero, Skenderbeg, led the resistance to the Turks. Albania was finally incorporated into the Ottoman Empire in 1479 where it remained a very poor rural province for several centuries.

Albania became independent from the Ottoman Empire in 1912. Kosovo (nearly half of Albania) was transferred to Serbia in the 1913 peace conference. Albania was overrun by successive armies in the First World War and became a kingdom only in 1928 under King Zog I. Mussolini's Italy occupied the country in the Second World War, when King Zog fled to Britain. The Albanian Communist Party, founded by Enver Hoxha, led the resistance against the Italians and then the Germans.

A provisional government was formed in 1944. In January 1946, the People's Republic of Albania was proclaimed. Enver Hoxha became president and remained in power until his death in 1985. Albania initially followed Soviet style economic policies but broke off diplomatic relations with the USSR and realigned itself with China from 1961 until 1981. Albania remained a communist state from 1944 until 1991, pursuing a policy of independence, while negotiating a series of foreign loans first from Yugoslavia, then the USSR and finally China. Albania's isolation from the rest of the world and lack of export earnings has contributed to its slow development and sustained poverty.

The Albanian government agreed to allow opposition parties in the early 1990s after communism collapsed in eastern Europe and the Albanian population staged demonstrations. The governing Party of Labour (later renamed the

Socialist Party), led by Ramiz Alia, won the election in March 1991 after promising the privatization of state lands. The Democratic Party, led by Sali Berisha, won the election in March 1992. Berisha was later elected President for a five year term from April 1992 to March 1997.

March 1997 saw the collapse of several pyramid savings schemes, in which perhaps two thirds of the population had invested money, with an estimated loss of US $ one billion *(22)*. Widespread violence followed in Albania since people blamed the government for alleged complicity in the schemes. Violence was particularly bad in the south of the country and many communes and municipalities ceased to function. The country's economic growth rate of the previous four years was reversed, inflation and unemployment rose and economic recovery was interrupted.

In the wake of the pyramid savings scheme disaster, the Socialist Party was elected in July 1997, and Fatos Nano became Prime Minister. After demonstrations in September 1998 between the followers of Sali Berisha, now the opposition leader, and the government, the Prime Minister's offices were ransacked. The rioters had access to guns and other weapons looted from government armament stores during 1997. Fatos Nano resigned and the new Prime Minister, Pandeli Majko, was nominated in late September 1998.

The 1976 constitution of Albania, abolished in 1991, was followed by interim constitutional provisions. A referendum for the new constitution was held on 22 November 1998 and the constitution was approved by the majority of voters. The Albanian legislature is a unicameral parliament of some 140 members. A number of political parties are represented. Executive power rests with the president who has a five-year mandate and who appoints a government of 18 members.

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

Each district has at least one municipality and a number of communes. For example, the Tirana district covers an urban municipality, three semi-urban municipalities and 15 rural communes, each with locally elected authorities. There are 315 communes and 42 municipalities in the country. Although,

theoretically, these have tax-raising powers, in practice local governments receive almost all their annual revenue from central government.

The economy and population health

Albania is one of the poorest countries in Europe. GDP is difficult to calculate, however, because of the extensive informal economy. Notwithstanding this, according to the best estimates, GDP per capita (adjusting for purchasing power parity) has fallen during the 1990s (Table 2). Real GDP per capita (PPP $) in 1995 was estimated at US $2853 but may have fallen to $1290 in 1996 *(2)*. This is low for the region compared to Bulgaria with PPP $4604 in 1995 *(23)*. Agriculture and forestry are the main sources of employment and income in Albania. Foreign remittances are also important, since about one quarter of the workforce (up to 400 000) work abroad and send money to their families *(9)*. The war in Bosnia, UN sanctions against Yugoslavia and Greek sanctions against Macedonia have all affected the Albanian economy, as has continuing internal civil unrest and most recently the war in Kosovo.

After the collapse of the centrally-planned system in 1991–1992, the country began the transition to a more open economy. The economy grew strongly between 1993 and 1996 as the government managed to control inflation and embarked on widespread privatization. The riots in 1997 and again in 1998, however, were major setbacks to political and economic stability. GDP plummeted in 1997 after four years of growth (Table 2). Government expenditure as a percentage of GDP has also dropped dramatically from 62% in 1990 to below 30% in 1996 with consequent constraints on government services.

Table 2. Macroeconomic indicators

Indicators	1990	1991	1992	1993	1994	1995	1996	1997
GDP growth rate (% change)[a]	-10.0	-27.7	-7.2	9.6	9.4	8.9	8.2	-15.0
Annual inflation rate (%)[a]	0	35.5	226.0	85.0	22.6	7.8	12.7	32
GDP $ per capita[c]	–	346	222	388	620	745	799	708
GDP PPP $ per capita[d]	3 000	3 500	3 500	2 200	2 788	2 853[b]	1 290	–
Government expenditure % GDP[a]	62.1	61.9	43.9	40.2	36.3	34.3	29.2	–
Registered unemployment rate[a]	9.5	8.3	24.4	24.8	16.1	13.9	12.3[b]	14.9[b]

Source: [a] UNICEF TransMONEE database 3.0; [b] UNDP Albanian Human Development Report, 1998; [c] European Bank for Reconstruction and Development 1998; [d] WHO Regional Office for Europe health for all database.

Registered unemployment fell in 1994 and 1995 as the economy improved but since then real unemployment has risen substantially. The Ministry of Labour and Social Assistance reported 19.1% unemployment in Tirana in 1995 – one of the highest in the country *(11)*. Registration figures underestimate true unemployment, however, especially since rural people are considered to be landowners after land distribution in 1994.

The 1997 crisis brought a sharp increase in the demand for cash assistance under the social insurance scheme (20% or 100 000 more people in April 1997 alone). Taking into account the rising number of families in need and the high inflation rates, the social insurance scheme is allocating less benefits in real terms. These benefits were already meagre prior to the 1997 crisis, averaging US $18 a month per family in 1996 *(22)*.

Albania is in the midst of a demographic transition with the high birth rate falling but also high rates of infant and maternal mortality. The epidemiological transition combines a continuing high prevalence of infectious disease with rising rates of chronic illness such as cardiovascular disease, which is the leading cause of death *(9)*.

The Albanian population in the past has enjoyed reasonable health on many measures, despite low incomes, very limited health services and frequent outbreaks of infectious diseases. In 1994, life expectancy in Albania was 69.2 for men and 75.0 for women (Table 3). This was only slightly below the average for western European countries and above the average for the countries of central and eastern Europe. Albania illustrates the link between healthier lifestyles and better health, both in comparison to other countries and also within the country itself, with better health indicators in the south than the north, a pattern that reflects dietary variation *(4)*. Albania has good nutrition with a traditional diet high in fruit and vegetables. The country has comparatively low levels of alcohol consumption and smoking, but these are said to be rising. Tobacco consumption has increased, as has cigarette smuggling, which makes it very difficult to estimate cigarette consumption in Albania.

Infant mortality rose between 1990 and 1994 but dropped to 26 deaths per 1000 live births in 1996 (Table 3). The infant mortality rate remains the highest in Europe and in the region; for example, compared to Bulgaria with 15.6 deaths per 1000 live births in 1996. Within Albania infant mortality is twice as high in some rural areas as in urban areas (although infant mortality has recently increased in Tirana). These figures, however, are said to be under-reported in 1993 and over-reported in 1994 *(9)*. Statistics on life expectancy and infant mortality under the previous communist regime were manipulated, so that it is very difficult to make comparisons with statistics from the communist era.

Table 3. Health indicators

Indicators	1989	1990	1991	1992	1993	1994	1995	1996
Female life expectancy at birth[a]	75.5	75.4	–	74.3	74.3	75.6	–	–
Male life expectancy at birth[a]	69.6	69.3	–	68.5	68.5	69.5	–	–
Infant mortality rate (per 1000 live births)[a]	30.8	28.3	32.9	30.9	33.2	35.7	34.0	25.8
Under 5 mortality rate (per 1000 age group)[a]	45.5	41.5	44.5	56.8	62.9	–	–	–
Maternal mortality (per 100 000 live births)[a]	49.5	37.7	29.7	31.5	28.0	40.6[a]	28.5[b]	24.8[b]
Abortions per 100 live births[a]	18.0	21.2	26.2	30.9	54.2	43.3[a]	44.7[b]	40.5[b]

Source: [a] UNICEF TransMONEE database 3.0; [b] Ministry of Health

A number of vaccine-preventable diseases are still common in Albania. Mortality rates for infectious, parasitic and respiratory diseases are high for infants and young people. Epidemics of cholera, typhoid and poliomyelitis have broken out in the last few years in 30 out of 37 districts. There was a severe cholera epidemic in 1994. There are also high rates of pulmonary tuberculosis and hepatitis, which partly reflect unhygienic conditions and poor sterilization procedures. There is no clear picture of morbidity since statistics are collected mainly only from hospital admissions *(11)*.

Maternal mortality, at over 30 per 100 000 live births, was four times the average for western Europe but has improved since 1995. However, it remains higher, for example, than in Bulgaria with a rate of 19.4 in 1996. Poor prenatal care may account for some of this high rate as well as deaths from abortions. Abortion was illegal before 1992 and rates have risen since then with over 40 abortions for every 100 live births. Health services do not as yet offer comprehensive family planning with alternative methods of birth control *(11)*.

Historical background

Before the Second World War, Albania had few and mainly foreign-trained doctors, and a small number of private hospitals and institutions run by religious groups. Most of the population did not have access to facilities, which were mainly based in urban areas. Access improved after 1945 when a health care system was developed based on the Soviet 'Semashko' model. The first medical school was opened in Tirana and many medical experts also trained in the Soviet Union.

Despite becoming isolated from the Soviet Union in later years, many aspects of health policy and planning in Albania continued to follow the Semashko model. Sanitary-epidemiology stations were set up in each of the 26 districts. During the 1960s, an extensive primary health care system was developed, providing every village with at least a midwife to carry out antenatal care and immunizations. However, in the 1970s, the emphasis switched to hospital care. Hospitals were constructed in every district to provide basic inpatient care and also specialist outpatient care by polyclinics.

By the 1980s, the Ministry of Health provided and regulated all health services through the country's 26 administrative districts. District administrators also received instructions from the district executive committee of the communist party, and had very limited power in terms of budget use and personnel management. Health services were organized and controlled from the centre in vertical programmes, administered at district level through separate directorates responsible for medical care. These included hospitals, outpatient specialized polyclinics and primary health care centres, hygiene and epidemiology, dentistry and pharmaceuticals. The clinical (tertiary care) hospitals were run directly by the Ministry of Health.

The Ministry of Health appointed the directors of health institutions, mostly doctors, who simply implemented the instructions of their superiors. They had little discretion in improving services such as reallocating staff. The Ministry of Health could not control their day-to-day activities, however, except to dismiss them if they broke the rules. There was no training in management, no working guidelines, no performance indicators or incentives, and little research and development in health care. Some indicators were considered by the Ministry of Health and the communist regime to be extremely important. For example, being aware that infant mortality is a good indicator of the socio-economic conditions of a country, the communist authorities made its reduction a priority, but this also included (as in all Soviet countries) adopting a definition of infant mortality that excluded neonatal deaths.

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

The quality of services was poor, there was little ongoing training and, in particular, the overstaffing of hospitals was maintained at the expense of low salaries. Levels of medical technology were also very low and equipment was

outdated due to the fact that capital investment in the health care system had dropped in the 1980s *(9)*. Thus, at the beginning of the 1990, the average age of medical equipment in Albania was 25 years *(17)*. The continuing high rates of infant mortality and outbreaks of infectious diseases in the 1980s indicated that the country's health services were not able to respond effectively to these problems.

The effect of civil conflict on the health system

Albania has suffered several additional setbacks to its government services and also to its health care services. During the political changes in 1991 and 1992, and the accompanying violence, almost one quarter of health centres in cities and two thirds of health posts in small villages were destroyed *(9)*.

The violence in early 1997 also involved widespread looting of drugs and equipment, and some destruction of district hospitals, health centres and public health departments. Most hospitals were reduced to giving emergency care only, and about 30% of medical staff abandoned their posts especially in the south of the country. Immunization programmes were seriously disrupted, including damage to the refrigeration and transport of vaccines, disease surveillance effectively ceased, and water purification and human waste disposal broke down in many areas *(22)*. The financial crisis also left some hospitals unable to pay their employees' salaries, in some cases for as long as two months.

The civil unrest revealed continuing weaknesses in the Albanian health system in terms of its lack of administrative and communications capacities to respond to a crisis. It is unclear whether the attacks upon health services were part of the population's generalized anger towards government, or whether they also indicated serious dissatisfaction with the health sector. Albania's health care system had begun to recover, although it had not resumed full functioning, when political faction fighting broke out in late 1998.

The situation in the neighbouring Serbian province of Kosovo (or Kosova) has long been volatile. War broke out in 1998, when ethnic Albanians, who make up 90% of the 1.8 million population, sought independence from Serbian rule. NATO intervened in March 1999 to force the withdrawal of Serbian forces and in an unsuccessful attempt to secure the safety of Albanian refugees within Kosovo. By late April 1999, over 700 000 ethnic Albanians had fled Kosovo into the neighbouring countries of Montenegro, Macedonia and Albania, which struggled to cope with the massive humanitarian disaster. In late June 1999, after Yugoslavia had accepted peace plans put forward by the G8 countries and backed by the UN, the refugees began to return to Kosovo.

Organizational structure and management

Organizational structure of the health care system

The essential structure of public administration has continued largely unchanged in the 1990s since the advent of multi-party democracy, as has the structure of the health sector. Two public administration reforms, however, have impacted upon health services. First, more administrative authority has been deconcentrated from the centre to the regional (prefectorate) tier, which was created in 1993. There are about three districts in each region, and each district is responsible for administering district hospitals and polyclinics, specialist hospitals (such as tuberculosis hospitals), and primary care centres. The second reform aimed to strengthen the role of local government. In the health sector, some responsibility has been devolved for primary care in rural areas. The 1993 Local Power Law regulates the election of local authorities, their responsibilities, functioning and relations with the national government.

The Government has embarked on a consultative approach to update its strategy for health sector development. The Government of Albania, the Government of Switzerland and the World Bank jointly organized a meeting of donors on Albania's health sector in February 1999. The meeting set up a support group to assist the Government in preparing a development strategy. The plan is scheduled for completion by October 1999, and is to emphasize the following themes.

First, the Government is committed to a health system that will focus on the most important causes of illness, disability and premature death. A major challenge is the provision of cost-effective services in an equitable and efficient fashion.

Second, the theme of governance and regulation aims to develop the capacity of the Ministry of Health and central agencies to identify and perform the key strategic tasks. These tasks include the formulation of national health policies

and strategies, preparation and dissemination of guidelines for implementation, accreditation, quality assurance, regulation of private sector activities and criteria for capital investments. A strong centre will be developed in tandem with carefully planned decentralization of planning and management functions. There are ongoing activities to develop district health management teams with support from the Government of Canada and the World Bank. A regional health authority is being developed in the Tirana area, with support from the Government of the United Kingdom and the World Bank.

On the third theme of health sector finance, the Government is committed to a strategy that will: (a) increase the overall level of resources available to the health sector; (b) improve the fit between revenue allocation and needs; and (c) maximize the efficiency with which resources are utilized, as well as transparency in the use of funds. The United Kingdom (Department for International Development), the United States Agency for International Development (USAID) and the World Bank are supporting these activities.

On the fourth theme of infrastructure, the Government recognizes the need to introduce modern techniques for managing public health facilities and for regulating the private sector. Health facility maintenance has received support from the European Union PHARE programme.

Finally, emphasis will be placed on the development of human resources. The Government is committed to developing a system of integrated health services, with an emphasis on primary care provided by general practitioners and community nurses, as well as further training or re-training for hospital staff. The introduction of professional managers is regarded as essential.

Ministry of Finance

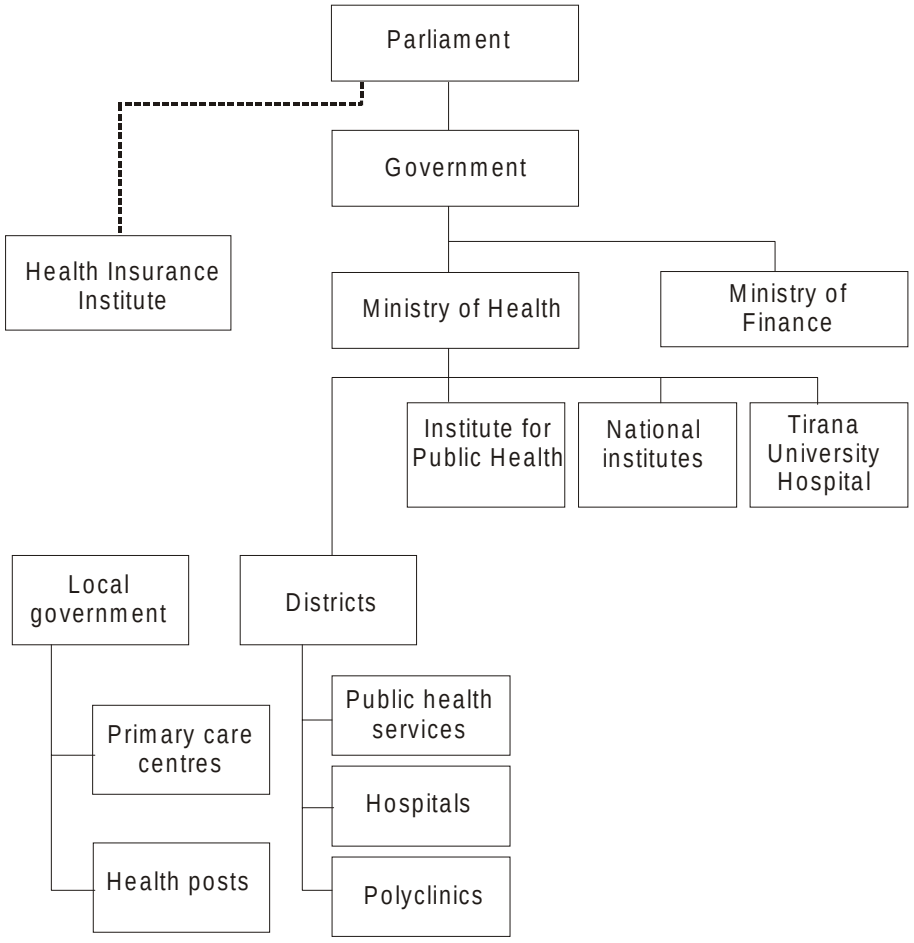
The Ministry of Finance allocates funds to the other ministries, including the Ministry of Health, as well as an earmarked budget to local governments.

Ministry of Health

The Ministry of Health remains the major funder and provider of health care services. The Ministry has been reorganized but continues to take the lead role in most areas of health care. It ‘owns’ most health services with the partial exception of primary care.

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

Fig. 2. Organizational chart of the health care system



organizations, and for the administrative districts, to obtain quick decisions *(11)*. The need to administer foreign aid has added to this imbalance. The growing private sector also is inadequately supervised.

Directorates used to be organized around separate vertically integrated services (such as maternal and child health) but have been replaced with a hospitals directorate and a primary care directorate. The directorates are administered mostly through the Ministry of Health district bureaucracy. For example, in the district of Tirana (which contains virtually all the tertiary care

facilities) services are run by separate organizations and directorates. These include Public Health, which is responsible mainly for urban primary health care and outpatient clinics; Primary Health Care for the rural Tirana district; Public Dentistry; Tirana Blood Centre; Tirana University Hospital; Lung Diseases Hospital; and the Obstetrics and Gynaecology Hospital.

The Institute of Public Health, under the Ministry of Health, is responsible for health protection (especially the prevention and control of infectious diseases and the national programme of vaccination), environmental health and the monitoring of drinking water and air quality. It works mainly through the district public health services. Monitoring of food quality is a shared responsibility between the Ministry of Agriculture and the Ministry of Health.

Health Education and Promotion is coordinated by the National Centre for Health Education/Promotion under the Ministry of Health.

Until recently, the Ministry of Health was also in charge of Environmental Protection. Currently, this function is performed by the Agency for Environmental Protection which is part of the Prime Minister's office.

Health Insurance Institute

The other major health system change has been the introduction of health insurance in 1995. The Health Insurance Institute is a single national statutory fund, which in 1996 was given autonomy as a quasi-government body accountable to Parliament. Insurance is being introduced cautiously in a series of planned stages. Individual contributions to the national fund are, in principle, compulsory. Nearly 70% of the population was covered by 1997. So far, the Health Insurance Institute funds only the salaries of primary health care doctor and also essential pharmaceuticals.

Local governments

About 320 local government authorities are now partly responsible for primary health care. These rural local authorities (communes) are the owners of these primary health care facilities. They receive earmarked grants from the Ministry of Finance for maintaining and equipping primary health centres and outposts, and for their operating costs, the upgrading of facilities and the payment of some staff salaries. In urban areas the services are administered by the Ministry of Health district offices.

Planning, regulation and management

A national policy for the health sector was produced in 1993: *A New Policy for the Health Care Sector in Albania (5)*. This plan has not yet been updated to reflect developments in the health sector. In 1996, the Ministry of Health, in cooperation with WHO, produced a working paper setting out medium term policy options. However, the financial crisis and change of government in 1997 interrupted this process *(10)*. Some efforts were made to plan and prioritize health services, but most attention concentrated on maintaining services, and on responding to the crises caused by periodic civil violence. However, the Ministry of Health has produced sub-sector plans with the support of international experts. These include a policy for primary health care, which was developed with assistance from the European Union PHARE programme; plans for the development of Vlorë and Shkodër regional hospitals; a strategy for the Tirana regional health system, produced with the assistance of the World Bank; and the masterplan for the development of the Tirana University Hospital, with the assistance of the Assistance Publique des Hopitaux de Paris. There is widespread recognition of the need to integrate these and other plans under the framework of a national policy and plan for the health sector in Albania.

There is little continuity within the Ministry of Health and its institutional memory has been lost with changes in personnel. Each government replaces the senior and even middle level managers and much documentation goes with them. The Ministry of Health has not been able to set up a system of preserving its "technical memory". The planning capacities of the Ministry of Health are weak, since day-to-day administration must take priority.

Regulation takes place through the bureaucratic system and is not separated from management. Few separate regulatory bodies have yet been established. Considerable work needs to be done on setting standards of care, on quality assurance, and on consumer protection. Efforts to develop standards for hospital accreditation, which could be used as a means of rationalizing the distribution of hospitals, have not really progressed. For example, some district hospitals have not been upgraded to regional hospitals because of a conflict of interest between districts. The hospital map of the country has, therefore, not yet been defined and the process of accreditation has stalled.

An Order of Physicians, established in 1993, has assumed responsibility for professional standards and for the registration of doctors. Professional self-regulation is weak, however, and there are few performance incentives in the health care system. Professional self-regulation is even less developed for nurses.

Management functions require urgent attention. Albania does not have professional management specialists. Managerial performance is seen more in terms of political commitment than effectiveness and efficiency outcomes. Funding is largely determined centrally by global budgets allocated at the start of each financial year. District administrators and health care managers have little flexibility to manage effectively. There is an urgent need to establish management information systems, which would also provide relevant and accurate programme and budgeting information.

Other stakeholder groups such as professional associations, unions and consumer groups play little role in planning or regulation. Health services providers are still not accountable to their patients, although a complaints system is to be introduced.

Decentralization of the health care system

The health system remains highly centralized and hierarchical, despite some control being decentralized. Administrative responsibility (but not political or policy responsibility) has been deconcentrated to the 36 districts, although these remain accountable to the Ministry of Health.

Primary health care has been largely devolved to local governments (communes and municipalities) to run and maintain these facilities. Primary care doctors mainly use local government facilities but receive their salaries from the Health Insurance Fund based on patient capitation.

Privatization has proceeded mainly with dental practices and pharmacies. Hospitals, polyclinics, health centres and posts remain under public ownership. Private medical practice and private insurance have been legalized since 1992 but have yet to develop.

The recently formed Health Insurance Institute is a new player, the intention being that this fund will take over a larger health funding role.

No decision has yet been made about the extent or form of future decentralization or privatization. The Ministry of Health apparently intends to keep the district as the basic administrative unit and to transfer more autonomy in planning and management. The rationale is the preservation of the district health pyramid. District Health Boards, with decision making powers for strategy and planning, will be set up. This model is to be piloted in the Tirana region, with support from a World Bank project. Another option is for the 12 prefectorates (regions) to assume responsibility for planning, technical support and supervision, while the districts would continue to be responsible

for day-to-day running of the health system. Another proposal is for greater separation between purchase and provision. For example, the ownership of health facilities could be devolved to semi-autonomous bodies or private settings funded through the Health Insurance Institute, or funded by other private health insurance companies that might emerge in the future.

Health care finance and expenditure

Main system of finance and coverage

Albanian health care finances remain at a very low level and the emphasis throughout the 1990s has been how to do more with less. The key problem facing the Albanian government, after the transition to a multi-party democracy in 1992, was finding the finances to maintain essential health services given a very small government budget.

There is little information on the scale of funding before 1990. In communist ideology, health care was considered a non-productive sector and thus a low priority. In 1987, health expenditure in Albania was estimated to be 3.0% of GDP compared to a central and eastern European average of 2.8% and an European Union average of 7.3% *(23)*.

Health service funding is a mix of taxation and statutory insurance. The bulk of funding still comes from the state budget but the tax base is problematic given the low incomes of the population, the large informal economy, and problems with tax collection. In 1996, nearly 50% of health finances came from the state budget, 9% from citizens' insurance contributions, 16% from out-of-pocket patient payments and about 26% from foreign aid (Table 4).

The Ministry of Finance allocates money to the Health Insurance Fund (mainly to cover unwaged groups) and to the Ministry of Health. The Ministry of Finance also allocates an earmarked budget to local governments mainly for primary care. The recurrent funds are for some staff salaries, and the capital funds are to upgrade and maintain health centres and health posts. This amounted to 6% of the health budget in 1996 *(9)*. This figure shows that basic health services in the rural communities are under-financed. The inefficient use of these meagre funds by local authorities further exacerbates the poor quality of preventive and curative services in rural Albania. In principle, local government could also raise revenue for health care, but this remains a very small amount.

Table 4. Percentage of main sources of finance, Albania, 1990–1996

Source of Finance	1990	1991	1992	1993	1994	1995	1996
Public							
• State budget/M of Health	84%	68%	56%	56%	59%	48%	39%
• State payment to HII	0	0	0	0	0	6%	4%
• State payment to local govt	0	0	0	7%	10%	9%	6%
• Citizen insurance	0	0	0	0	0	7%	9%
Private							
• Out-of-pocket	16%	9%	6%	7%	9%	14%	16%
• Private insurance	0	0	0	0	0	0	0
Other							
• Foreign aid (a)	–	23%	38%	30%	22%	16%	26%
Total (US $ millions)	$83.5	$65.64	$39.39	$49.6	$69.15	$94.09	$126.65

Source: Ministry of Health and Environmental Protection of Albania and WHO Regional Office for Europe 1996, Background Document 1, Derived from Table 6.
Note: (a) Annual average calculated for foreign aid amounts across 1991–1995 and 1996–1998.

The Ministry of Health share of health funds shrank from around 84% in 1990 to below 40% in 1996 as other sources of funds increased. The Ministry of Health remains the major funder and provider of health care.

The Health Insurance Institute

The national Health Insurance Institute (HII), created in 1995, is a single national statutory body. The aims in establishing the Institute were to seek another source of finance for health care, offer a broader range of health care services, control administrative costs and ensure equity in a small country. The national Health Insurance Institute was created as an autonomous body, and in 1996 was made accountable only to Parliament. A single payer fund, rather than multiple funds, was set up as this structure was deemed best able to cover a country with a small population, to act as a strong regulator, and keep administrative costs low.

The Health Insurance Institute by design remains a limited scheme. It has been introduced in stages, premium contributions have been kept low, different rates were set for different population income groups, and a restricted package of health services and pharmaceuticals was defined.

The Health Insurance Institute covered 68% of the Albanian population in July 1997 *(12)*. However, coverage varies across population groups. About one quarter of the workforce were covered. Among employees in state-owned enterprises, 88% were covered, but only 56% of employees in privately-owned enterprises, and only a tiny 3% of farmers. This last group is very important

since it represents almost one quarter of the country's population. One reason for the low enrolment is that farmers cannot afford both the Health Insurance and the Social Insurance contributions. Another explanation could be the lack of incentives to contribute; the scheme covers very limited services and many doctors do not wish to refuse people who have not contributed. Most of the unwaged, such as children, women who work in the home and the elderly, are covered.

The Social Insurance Fund also collects and distributes health insurance funds through its regional branch offices (with some adjustment across regions). Health insurance rates are set according to income rather than health risks. Employees contribute 1.7% of net salary collected by employers as payroll deductions. The self-employed contribute between 3%–7% of their income, depending on whether they live in rural or urban areas. Lower rates were set for private farmers. The state pays the contributions for the unwaged. State contributions now account for nearly half of the Health Insurance Institute (Table 5).

Table 5. Health Insurance Institute: Revenue and expenditure (Leks million*)*

	1995	1996	1997	1998
Revenue				
• Contribution of employees	27%	30%	29.3%	26%
• Contribution self-employed/others	30%	28%	25%	27.5%
• Farmers	1%	8%	0.7%	0.5%
• State contribution	42%	34%	45%	46%
Total %	100%	100%	100%	100%
Leks (million)	871	1 475	1 755	2 321
Expenditure				
• Drug reimbursements	73%	68%	74%	75%
• Payments to GPs	18%	25.5%	21%	18%
• Administrative expenses/investments	9%	6.5%	5%	7%
Total %	100%	100%	100%	100%
Leks (million)	4 137	1 270	1 623	2 378

Source: Institute of Health Insurance, Albania.

The Health Insurance Institute managed a budget surplus in 1996 and 1997. The accumulated surplus went into a Reserve Fund, which was able to cover the 1998 deficit caused by the civil emergency.

Coverage was introduced in stages. In the first stage from 1995, only primary health care physician salaries and essential pharmaceuticals were covered. By 1997, entitlements covered free family doctor services, and subsidies on 278 products on the essential drugs list *(12)*. The next stage, starting in

1999, will be full coverage of basic health care services from the insurance fund, including GP wages, nurses and midwife wages and operational costs. This will be implemented on a pilot basis in Tirana and, if successful, extended to the rest of the country. The Health Insurance Fund will also trial the purchase of specialized outpatient services.

In 1998, the Health Insurance Institute spent 75% of its budget on drugs, 18% on general practitioner salaries and 7% on administrative costs (Table 5).

The Health Insurance Institute has encountered inevitable implementation problems. Prices, reimbursements and premiums all need to be adjusted. Service providers do not differentiate between insured and uninsured patients. Administrative and funding arrangements between Health Insurance Institute and Social Insurance Institute funds remain blurred. The proposed reforms aim to reduce the government contribution to the Fund (currently nearly half) and increase the population contribution. This will be difficult, however, given the serious economic and political problems Albania is facing in addition to the 1999 Kosovo refugee crisis.

Health care benefits and rationing

Under the communist state, all citizens were entitled to free health care, with small co-payments for drugs. Drugs were sold in public pharmacies at subsidized prices. Drugs were free in public pharmacies for patients with cancer and tuberculosis, and for children under one year of age. The health care system was unable to provide a comprehensive range of services to the whole population, however, and did not provide services such as some expensive surgery.

Eligibility for free primary care and pharmaceuticals, in theory, is restricted to patients who have paid their insurance contributions, although some population groups, such as many farmers, cannot afford insurance. However, the state is regarded as responsible for low-income groups and in practice, people are not refused medical services. Inpatient services in Albania legally are offered free of charge to the population in public facilities, although the quality of care is often low. This includes long-term treatment such as for tuberculosis and cancer. Children aged 0–12 months old are automatically insured by the state budget and receive free essential drugs.

Health Insurance Institute cover remains restricted to primary health care and basic pharmaceuticals.

All dental care has been privatized except for emergency dental care and dentistry for children up to the age of 18 years. There are also co-payments for abortion.

Access to health care services is still restricted by the ability of the country to afford a full range of services and to replace the facilities and services damaged during civil unrest. Another major access barrier is that doctors and nurses have left medical facilities in many rural areas due to economic and social factors, and because the state cannot guarantee their security.

Complementary sources of finance

Extra budgetary sources of finance have been sought from the population and from outside sources to make up the shortfall in the state budget for health care. The two main sources are foreign aid and consumer payments, as explained below.

Out-of-pocket payments

Out-of-pocket (official) payments account for an increasing proportion of health care revenue. These payments fell in the early 1990s but had risen to about 16% in 1996 (Table 4). However, the full extent of out-of-pocket payments is unknown, although it is likely that such payments prevent low-income people from obtaining services and pharmaceuticals.

Co-payments by patients are set at a low level and were not intended to be a major source of revenue. These mainly apply to outpatient services and pharmaceuticals but not to inpatient care. Albanians have always paid part of the drug price in pharmacies. The free market economy and privatization of all pharmacies brought higher prices but, to a large extent, these have been mitigated by the health insurance scheme which subsidizes part of the price of essential drugs. Pharmaceuticals on the essential list are fully or partly reimbursed, while other drugs, most dental care and some other services are paid for out-of-pocket.

Under-the-table payments to doctors and other health professionals are said to be widespread in Albania but the extent is unknown *(9)*. Such payments are common in central and eastern Europe, including in the neighbouring country of Bulgaria (Delcheva et al 1997). According to the World Bank Development Report, under-the-table payments are estimated at 25 % of total health revenue in Romania and around 20% in Hungary *(18)*. A survey conducted in Albania concluded that the most common bribe paid by private citizens is for medical services. “More than 40% of those private citizens that admitted to paying bribes, paid bribes to state medical workers. Public officials identified state

hospitals as the fourth most corrupt institution in Albania, after the judiciary, customs and the privatization agency" *(20)*.

Voluntary health insurance

Private insurance and private medical practice have been legal in Albania since 1994. Private insurance funds have not as yet sought to enter the market given the current economic and political conditions. There is only one private Insurance Institute (InSig) which offers private health insurance for limited periods of time for Albanians who travel abroad.

External sources of funding

External aid accounts for a considerable proportion of health care revenue. During 1992 to 1993, this amounted to over one third of health revenue in the country. The real value of foreign aid doubled in 1996, but as domestic spending on health also rose during this period, foreign aid declined to about 26% of total health care finance (Table 4).

External aid comes from foreign governments and from nongovernmental organizations (NGOs). The main contributors are listed here in order of magnitude of the funds committed. These are the World Bank, the Catholic Church, the European Union PHARE Programme, the Government of Germany, the Government of Italy, the European Union ECHO Programme, OPEC Fund, the Government of Switzerland, the Government of the Netherlands, UNICEF, UNFPA, the Government of the United Kingdom, USAID, the Government of France and WHO. The World Bank is providing credits to the Government of Albania on two major projects: Health Services Rehabilitation and also for Health System Recovery and Development.

Health care expenditure

There are few statistics on health care expenditure before 1992. Statistics since then also vary according to the sources, or are unavailable since the Ministry of Health lacks the capacity to produce a systematic and reliable time series. Health expenditure figures from one year are also often revised in subsequent years.

Health expenditure has to be considered within the context of the country's struggling economy and low, and very variable, GDP. The proportion of GDP spent on health is an underestimate, since out-of-pocket payments are considerable although unknown.

In 1997, Albania spent the lowest proportion of GDP on health care of all central and eastern European countries with 3.1% of GDP (Table 6), compared to a central and eastern European average of 5.3%, and a western European average of 8.5% (Fig. 3 and Fig. 4). The context was negative GDP growth until 1993.

Public expenditure accounts for most of the health budget throughout the 1990s, although the insurance contributions must be taken into account for 1995 onwards. In 1997, public sector health expenditure was US $48 million (Table 6), accounting for nearly 70% of total health expenditure compared to 90% in 1994. Private health expenditure appears to have grown steadily from US $6.52 million in 1994 (pre-insurance scheme) to US $18.1 million in 1997.

Health care spending has gone through several phases in the 1990s. During the severe recession of 1990–1992, spending on health care halved. Also, an increasing proportion of health care funding, nearly 40% in 1992, was derived from foreign aid *(9)*. From 1993 until 1996, spending on health care increased each year, and by 1996 was US $85.14 million. Expenditure dropped to US $70 million in 1997; at the time of writing the 1998 figure was not available (Table 6).

Table 6. Health expenditures in Albania

Total health expenditure (% of GDP) *Source*: Estimation from MOH, 1998

1990	1991	1992	1993	1994	1995	1996	1997	1998
4.4	7.5	3.6	2.8	2.8	2.9	3.2	3.1	–

Total health expenditure/million US $ *Source*: Ministry of Health, 1999

1990	1991	1992	1993	1994	1995	1996	1997	1998
–	–	–	34.68	54.23	71.4	85.14	70	–

Public total investment in health/million US $ *Source*: Ministry of Health, Economic Department

1990	1991	1992	1993	1994	1995	1996	1997	1998
–	–	0.85	3.21	3.63	6.53	5.55	3.68	5.52

Public sector health expenditures(% of GDP)

1990	1991	1992	1993	1994	1995	1996	1997	1998
–	–	4%	3%	3%	2%	2%	2%	–

Public sector health expenditures/million US $ *Source*: Ministry of Health, Economic Department

1990	1991	1992	1993	1994	1995	1996	1997	1998
–	–	29	33	49	60	58	48	–

Private health expenditures/million US $

1990	1991	1992	1993	1994	1995	1996	1997	1998
–	6.06	2.29	3.45	6.52	13.4*	19.5*	18.1*	–

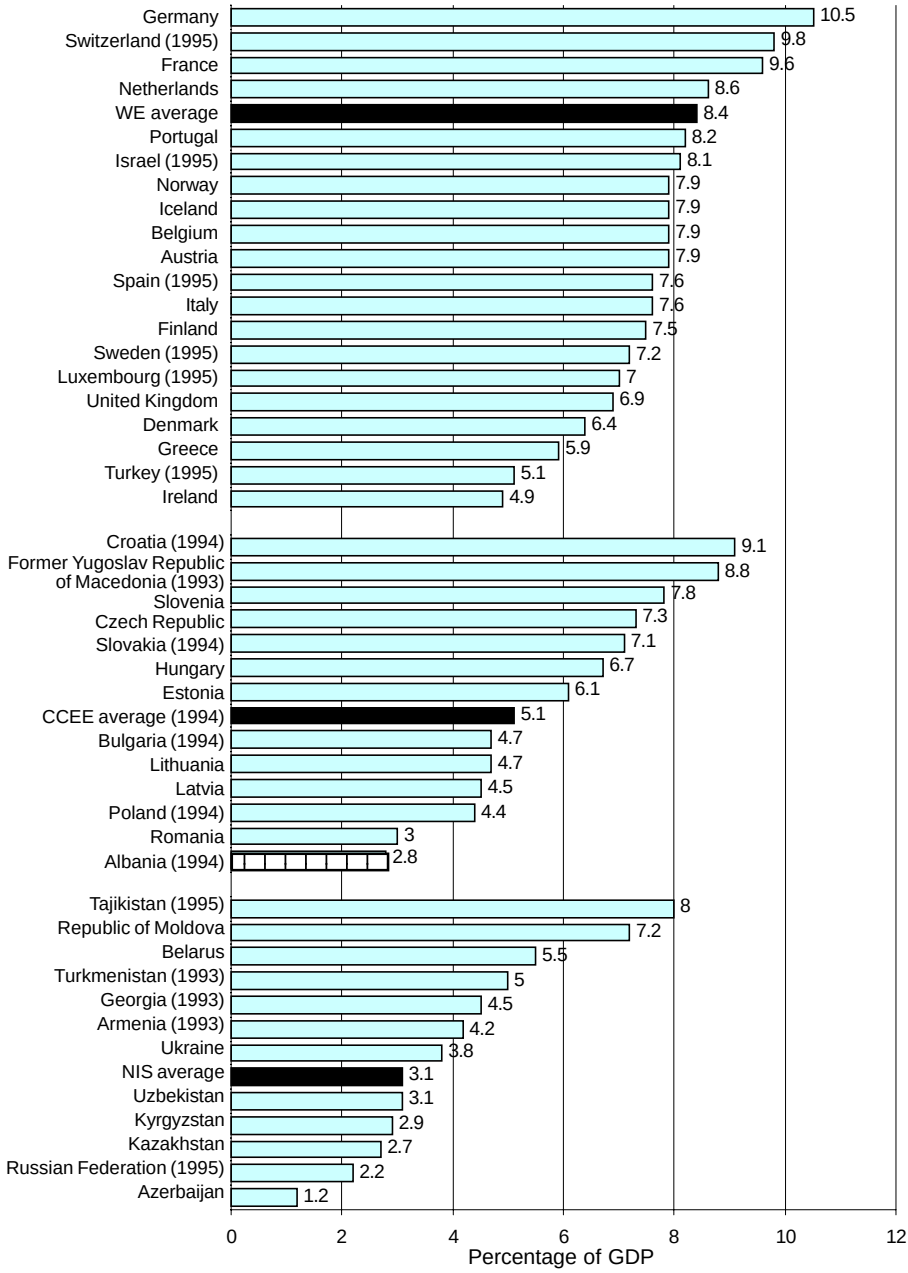
*Estimated figures

Private health expenditures (% of GDP)

1990	1991	1992	1993	1994	1995	1996	1997	1998
–	–	0.3%	0.3%	0.3%	0.5%	0.7%	0.8%	–

Source: Estimates obtained from Ministry of Health, Albania

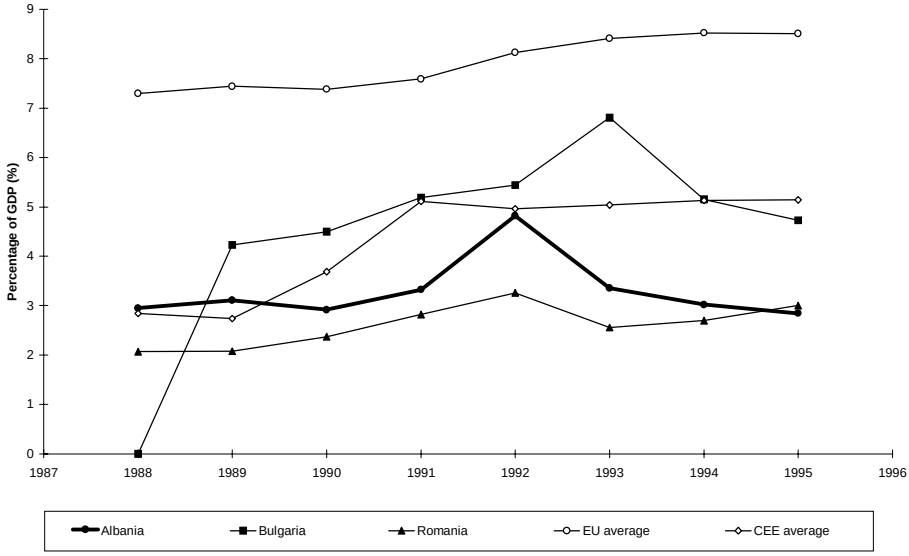
Fig. 3. Total expenditure on health as a % of GDP in the countries of the WHO European region, 1996 or latest available year



Source: OECD health data, 1996; World Bank; WHO Regional Office for Europe health for all database.

Albania

Fig. 4. Trends in health care expenditure as a share of GDP (%) in Albania and selected countries, 1989–1995



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

Structure of health care expenditure

Full time series statistics are not available on the structure of health care expenditure in Albania. In 1993 and 1994, 44% of expenditure went on inpatient care, which was at the low end of the range for the European region *(23)*, since inpatient care usually accounts for half or more of expenditure in European countries. However, the Ministry of Health budget figures for 1996 report expenditure on hospitals (which includes outpatient treatment) at around 54% *(11)*.

Pharmaceutical expenditure, as in other central and eastern European countries, took a large share of expenditure with 23% in Albania in 1994, but more recent figures are not available *(23)*.

Government investment in the health system varies considerably from year to year (Table 6) with around 5% of total health expenditure in 1997. In 1996, investment accounted for 12% of the state budget (Table 9). In 1996, 46% of investment funds were allocated to new constructions, 32% to rehabilitate existing infrastructure, and the remainder to equipment purchase *(1)*. Capital is invested in the Albanian health sector without a clear medium or long term

plan, and with no account taken of the running cost for consumables and maintenance. New structures deteriorate rapidly due to poor construction and maintenance. The poor facilities and lack of operational funds mean that high-quality care cannot be provided to patients.

Health care delivery system

Health care services are being delivered in the 1990s from poor facilities with inadequate equipment. These buildings were mainly constructed between 1960 and the early 1980s. Investment then lagged, with the result that by the 1990s health facilities were generally old, deteriorating and had obsolete equipment *(11)*. The government managed to increase investment during the 1990s, as mentioned earlier, although considerable damage had occurred during periods of civil disturbances.

Primary health care and public health services

A basic primary health care system, oriented towards the health of mothers and children, was established prior to 1990. However, many facilities were damaged in 1991 and 1992 (and again in 1997). In 1993, there were nearly 1000 health centres and over 2300 health posts (*ambulancas*) *(9)*.

In rural areas, a typical health centre is staffed by up to three primary care doctors and by nursing staff. Some doctors have not been adequately trained in family medicine. A health post, staffed by a nurse or midwife, provides maternity care, child health services and immunizations. Rural health services have ceased to function in some areas, however, due to a shortage of equipment and staff resignations.

In urban areas, large polyclinics provided outpatient specialist care, but are also now used by people as a first point of contact with medical care. Previously, even though general practitioners (GPs) were not highly respected as health professionals, patients had to go through them for a referral to specialists. This referral system is now not functioning. The Ministry of Health has introduced fees payable by those who bypass their GPs, but so far this disincentive has had little effect. Another problem is that specialist doctors want to attract patients directly, because under-the-table payments are an important source of income.

The habit of bypassing primary care services has been hard to change, and patients still use specialists for first contact care.

Local government now owns primary care facilities in rural areas. In urban areas, health facilities are still owned by the Ministry of Health. This division in the decentralization policy of health services in Albania has produced underfunded rural health services run by local government, and better funded health services run by the Ministry of Health.

The proposed primary care teams will be led by family physicians. The planning guideline is for one family doctor per 2000 inhabitants in urban areas, and one per 1700 in rural areas. The intention is for the primary care team to act as a gatekeeper to secondary care, although there is no mechanism to ensure that this happens. Patients are free to register with the doctor of their choice, who is paid by the Health Insurance Institute on a weighted patient capitation basis, depending upon geographic area and other criteria.

Reform of the primary care system began in 1992, guided by the European Union PHARE programme, the World Bank and WHO. Primary health care facilities remain publicly owned with the exception of licensed private pharmacies and dental clinics.

The national plan for primary health care calls for 516 health centres (reduced from 1000) and 2200 health posts (reduced from 2300) across the country – amounting to at least one health centre in each commune and one health post in each village. Health centres are meant to be on separate sites from polyclinics, medical centres and hospitals. About 350 health centres had been renovated and re-equipped in 1996 (although many were damaged again in 1997), and others are being rebuilt by the Ministry of Health with the help of funds from the European Union PHARE programme and the World Bank.

One proposal is to integrate the separate services into primary health care teams. Tuberculosis prevention services (part of a national programme administered through the districts) would become part of primary care. Public health and preventive services such as school health and health education would be included, along with maternal and child health services and family planning. An integration pilot project is being set up in the Tirana region, based on the development of a regional health authority. The Government of Albania is being supported in this by the World Bank and the UK Department for International Development.

Maternal and child health is a high priority for a country with a young population structure. A high proportion of women were said to receive prenatal care under the previous communist system, especially since maternity leave cash benefits were tied to centre visits. Prenatal care services now are faltering in many areas. For example, about one quarter of pregnant women in

Tirana in 1996 did not attend a prenatal check-up until after 28 weeks of pregnancy *(11)*.

The government has adopted a family planning policy linked to better reproductive health services. Family planning has been practically non-existent. In the absence of other alternatives, women have resorted to abortion which was recently legalized with over 40 abortions for every 100 live births (Table 3). In 1996, 15 family planning services were offering their services in the Tirana district *(11)*.

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

Public health services

The National Institute for Public Health, reorganized in 1995 from the previous research institute in hygiene and epidemiology, is directly accountable to the Minister of Health. It has about 150 staff and is larger than the Ministry of Health head office. The Institute collects health statistics, runs immunization programmes, monitors the environment, and collects data on health status. The Institute does not yet offer advice on health policy but it provides technical support and acts as a national research and training centre.

Much of the responsibility for public health lies with the district directorates of public health and/or directorates of primary health care (each with a distinct structure and set of responsibilities). The directorates are accountable both to the National Institute for Public Health and to the Ministry of Health. Local authorities (communes and municipalities) are directly responsible for waste disposal, drinking water supplies and some forms of environment protection. Government sanitary inspectors are the responsibility of the Ministry of Health.

The National Health Education Centre is responsible for health education and promotion. It is accountable to the Primary Health Care Department of the Ministry of Health. The Centre's activities have still to be developed and there is as yet no national health promotion programme.

The national Blood Transfusion Centre is based in Tirana. Three regional centres are planned and there is a blood collection centre near most district hospitals.

Albania is 'an epidemic-prone' country *(22)*. The Albania Institute of Public Health, WHO and UNICEF have drawn up contingency plans for epidemics.

Public health is also endangered by the lack of many basic amenities. For example, in Tirana in 1996, households had running water for only a few hours a day, and this was contaminated from sewage system leaks *(11)*. During the April 1997 civil riots, the system for reporting disease broke down in half the districts, as did waste management in all districts except Tirana *(22)*. The Institute of Public Health, and many districts throughout Albania, are engaged in improving systems for monitoring infectious diseases with WHO assistance.

The Albanian Ministry of Health has put considerable effort into achieving good immunization coverage of children and maintaining cold chain conditions for vaccines across the country. After a drop in the early 1990s due to the budget crisis and civil unrest, immunization rates had improved, mainly through direct assistance from UNICEF. In 1996, over 90% of children were immunized against a range of infectious diseases *(23)*, including immunization of all newborn babies against Hepatitis B. In 1996, 92% of children were reported to have been immunized against measles, which compares well to other countries in the European region (Fig. 5), although the occasional outbreaks of measles casts some doubt on the validity of these data. The poliomyelitis campaign in April 1997 was carried out with foreign assistance *(22)*. In 1997, the lowest coverage of 94% was for tuberculosis and the highest coverage of 99% was for polio.

Secondary and tertiary care

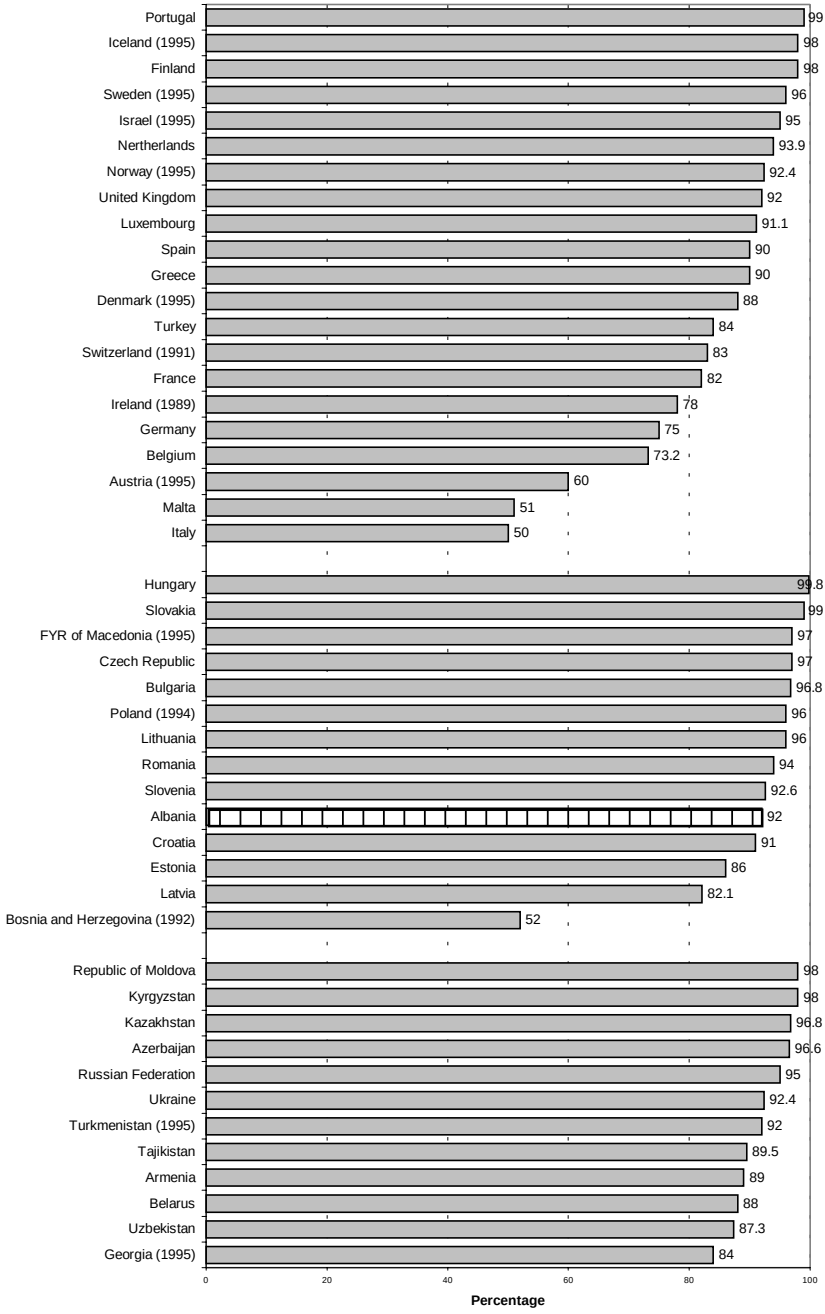
Secondary care

Hospitals remain publicly owned, principally by the Ministry of Health. The plan is to close small sub-standard hospitals and to reorganize hospitals at three levels: national, regional (prefectorate) and district. However, the ratio of hospital beds to population in Albania is amongst the lowest in Europe.

In 1992, there were 160 hospitals in Albania with 14 000 beds (i.e. 4.0 beds per 1000 population). This figure included many small rural hospitals that could not be regarded as offering secondary care.

The main change since 1992 has been the closure of many poorly-equipped small (mostly rural) hospitals. Some have been transformed into health centres. There are now 50 hospitals, including specialist hospitals and the military hospital *(9)*. The number of acute care hospital beds was drastically reduced from 14 000 in 1992 to 9600 by 1996. Long-term care beds have always been, and still are, in short supply in Albania. The exception was the so-called

Fig.5. Levels of immunization for measles in the WHO European Region, 1996 or latest available year



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

"dystrophic hospitals" (now closed) where severely malnourished children were treated although the level of malnutrition in the country was not acknowledged.

In 1995, there were 3.2 hospital beds per 1000 population (Table 7). This was already among the lowest level of provision in Europe, compared to the central and eastern European average that year of 7.2 and the European Union average of 7.1 (Figs 6 and 7).

Table 7. Inpatient facilities utilization and performance, Albania, 1989–1996

Inpatient	1989	1990	1991	1992	1993	1994	1995	1996	1997
Hospital beds per 1000 population	4.1	4.0	3.9	4.0	3.8	3.0	3.2	3.1	3.0
Admissions per 100 population	–	–	–	–	8.96	8.81	8.97	8.82	7.68
Average length of stay in days	13.5	13.4	13.7	12.7	9.0	9.0	8.2	8.1	7.9[b]

Source: WHO Regional Office for Europe health for all database. [b] Statistics Department, Ministry of Health.

Consistent with the low provision of hospital beds is a low hospital admission rate with 8.97 per 100 population in 1995, compared to the central and eastern European average of 18.7 and the European Union average of 17.9. The average length of stay in 1992 was over 12.7 days, which fell to 8.2 days in 1995, which was also low compared to other European countries (Table 8). One explanation for the short length of stay in hospital is the lack of equipment and drugs and the poor quality of service.

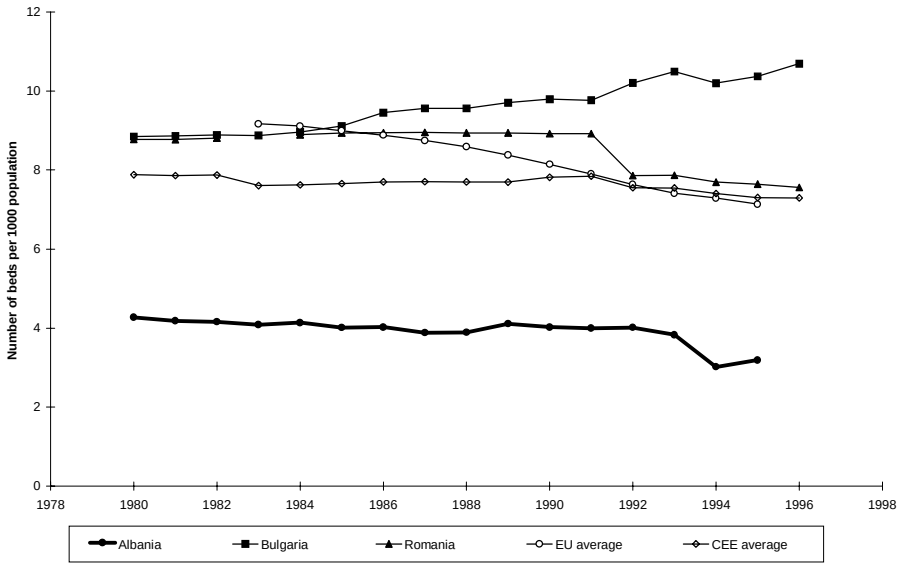
Hospital bed occupancy was reported as 54% in 1990 and 72% in 1994 *(9)*, which is low compared to western European countries (Table 8).

Inpatient secondary care is provided mainly by district hospitals. The Ministry of Health decided in 1992 to upgrade some hospitals but has not been able to achieve this objective. The plan was to upgrade a number of district hospitals (between six and twelve) to regional hospitals with 500 beds each, providing a wider range of medical and surgical specialities. Work has begun on two of these hospitals subsidized by the World Bank. It has been politically difficult to determine which hospital will be upgraded with 10–12 specialist services, and which hospitals will remain district hospitals or even be downgraded to four basic services (internal medicine, paediatrics, surgery and obstetrics/gynaecology). There are also hospitals for psychiatric care, tuberculosis treatment and rehabilitation. District hospitals (37 in all) with about 100–300 beds each, take patients from their emergency departments, as well as referrals from primary care, and refer patients if necessary mainly to the Tirana University Hospital.

Several nongovernment hospitals are in the process of being built. The Catholic Church is building a 200 bed private hospital. A Kuwaiti company is constructing a new, private, donor-financed orthopaedic and rehabilitation hospital in Tirana. OPEC is also providing capital to the Albanian government for a new public district hospital in Durrës. It is not yet clear whether the public sector will contribute any operational funds to these private hospitals.

All polyclinics, except for those in Tirana, are the responsibility of district hospitals, are headed by a hospital director, and use hospital staff. The plan is that polyclinics will offer specialized outpatient care after referral by a general practitioner. Specialized services, such as obstetrics/gynaecology and paediatrics, including the "consultation centres for women and children", are to be integrated within primary health care structures.

Fig. 6. Hospital beds per 1000 population in Albania and selected countries, 1980–1996



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

Tertiary care

Tertiary care remains very limited and located mainly in Tirana, including the following services:

- Tirana University Hospital "Mother Tereza", the biggest hospital in the country (around 1600 beds), offers secondary and tertiary care;
- Tirana Obstetric and Gynaecology Hospital offers secondary and tertiary care;
- Lung Disease Hospital offers secondary and tertiary care and long-term treatment for TB patients;
- The Military Hospital (under the authority of the Ministry of Defence) which specializes in traumatology, and also contains the university orthopaedic department.

The plan is for most tertiary care to be gathered into the 1500 bed Tirana University Hospital. The World Bank intends to invest some US $12 million in this hospital, according to a master plan prepared with help from the *Assistance Publique des Hopitaux de Paris (6)*. It will also act as a secondary care facility for patients from the surrounding district.

Social care

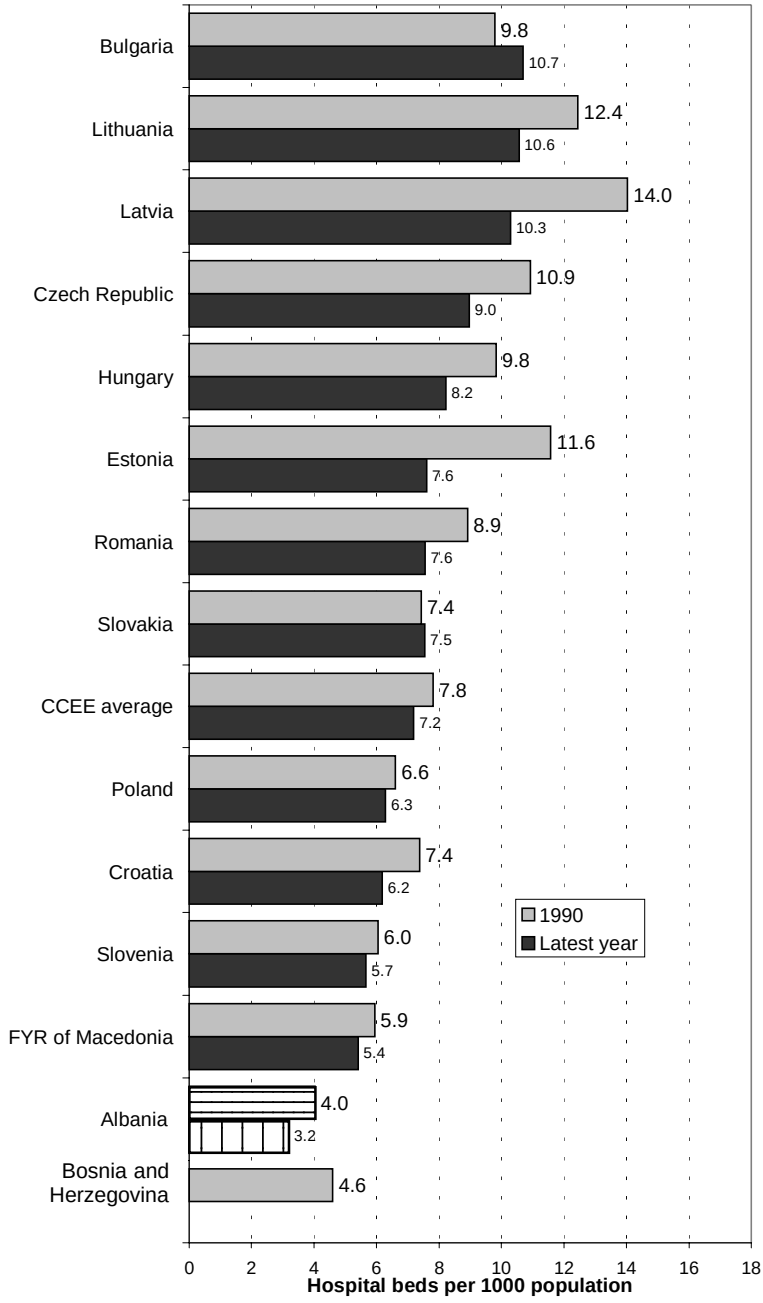
Only 5.9% of the population were aged 65 years and over in Albania in 1993, compared to the European Union average for that year of 15.2%. Ties within extended families are strong so that relatives care for most dependent older people. There are few residential homes for older people and no long-term elderly care hospitals.

There are a few large psychiatric institutions for the long-term mentally ill, but the quality of care is very poor and patients are isolated from their families. Some district hospitals also have psychiatric wards. The policy intention is to move towards caring for the long-term mentally ill in the community and to reduce reliance on institutions. There are some centres for people with learning disabilities, which are the responsibility of the Ministry of Labour and Social Care.

There are also beds in spas (*balnearies*) but these are not considered part of the health care system.

Social care is provided, therefore, in a few institutions but people mainly depend upon their families. Rehabilitation services and home support services

Fig. 7. Hospital beds per 1000 population in the countries of central and eastern Europe, 1990 and latest available year



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

Table 8. Inpatient utilization and performance in the WHO European Region, 1996

Country	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
Western Europe				
Austria	9.3[b]	24.7[b]	10.9[b]	75.9[b]
Belgium	8.3[b]	19.6[b]	11.4[b]	81.4[b]
Denmark	5.0[c]	21.6[c]	7.5[b]	81.7[c]
Finland	8.7[b]	26.8	11.6	74.0[b]
France	10.6[b]	22.7[b]	11.2[b]	75.4[b]
Germany	9.7[b]	21.5[b]	14.2[b]	81.3[b]
Greece	5.8	13.5[d]	8.2[b]	–
Iceland	10.8[e]	28.0[c]	16.8[e]	–
Ireland	3.7	15.1	7.5	82.3
Israel	6.0	18.6	10.1	94.0
Italy	5.9[b]	16.6[b]	10.5[b]	75.7[b]
Luxembourg	11.0[c]	19.4[c]	15.3[b]	–
Malta*	5.8	16.0[a]	4.56[a]	72.2[a]
Netherlands	5.3	10.2	13.9	73.2
Norway	13.5[c]	15.0[b]	10.0[b]	79.4[b]
Portugal	4.1[b]	11.3[b]	9.8[b]	72.6[b]
Spain	4.3	10.7[c]	11.0[b]	73.9[c]
Sweden	6.1[b]	18.5[b]	7.8[b]	75.9[b]
Switzerland	8.7[f]	15.0[c]	–	78.4[d]
Turkey	2.5[b]	6.3[b]	6.4[b]	55.6[b]
United Kingdom	4.5[b]	15.9[b]	9.9[b]	–
CCEE				
Albania	3.2[b]	9.0[b]	8.2[b]	–
Bosnia and Hercegovina	4.5[f]	8.9[f]	13.3[f]	70.9[f]
Bulgaria	10.7	17.5	13.2	64.1
Croatia	6.2	14.8	13.3	89.6
Czech Republic	9.0	20.4	12.5	74.3
Estonia	7.6	17.9	12.7	71.9
Hungary	8.2	24.2	10.3	74.4
Latvia	10.3	20.9	14.2	–
Lithuania	10.6	20.8	14.0	–
Poland	6.3[b]	–	10.8[b]	–
Romania	7.6	21.5	10.0	–
Slovakia	7.5[b]	18.3[b]	11.7[b]	79.2[b]
Slovenia	5.7	15.5	10.5	77.6
Former Yugoslav Republic of Macedonia	5.4[b]	9.7[b]	15.0	59.9
NIS				
Armenia	7.1	7.5	14.5	40.4
Azerbaijan	9.5[a]	5.7[a]	17.5[a]	–
Belarus	11.6	24.9	15.2	88.7[c]
Georgia	4.7	4.6	10.6	26.8[c]
Kazakhstan	8.4[a]	15.1[a]	16.5[a]	80.8[a]
Kyrgyzstan	8.4	16.4	14.9	80.5
Republic of Moldova	12.1	18.9	18.1	80.8
Russian Federation	11.6	20.5	16.9	87.7
Tajikistan	7.2	10.7	15.0	59.9
Turkmenistan	11.5[c]	17.0[c]	15.1[c]	63.6[c]
Ukraine	10.8	20.2	16.8	81.9
Uzbekistan	7.9	16.2	13.9	–

Source: OEC Health Data File, 1996; WHO Regional Office for Europe health for all database.

Note: [a] 1997, [b] 1995, [c] 1994, [d] 1993, [e] 1992, [f] 1991; *Data for Malta was obtained from the Department of Health Information in Malta, this is based upon data for acute general hospital care.

Albania

(such as home nursing) remain very underdeveloped. In the last few years, the first groups of social workers have graduated from the University of Tirana, after teaching support from various foreign universities. This profession is new to Albania and most people are employed by nongovernmental organizations (NGOs) that recently have started social care activities in the country.

Human resources and training

Albania has low population rates of trained health care professionals in comparison to other European countries. Furthermore, the distribution of health care professionals remains problematic, as for ex-Soviet model health care systems generally, with a high concentration in hospitals. At the end of 1995, the health care public sector employed 28 721 people, a drop of 18% from 1991 *(10).*

The Ministry of Health (through its Directorate of Human Resources and the district health teams) recognizes the need to devise effective policies on human resources in collaboration with professional bodies, such as the Chamber of Physicians and nurse organizations. However, these organizations have at present only limited experience in human resource policy making and planning.

Medical training

Doctors are trained at the Faculty of Medicine in the University of Tirana. Since 1991, admission has been on a competitive basis, with the numbers of students determined by the government. The medical degree takes six years and about 200 medical students graduate each year. There is a competitive exam to enter specialist training and most training takes three to four years. There is a bias towards medical specialization which, until the mid-1990s, was not standardized across training institutions.

There was previously no training in general or family practice. From 1997 onwards, family doctors will be trained in a new two-year postgraduate course in family medicine at the University of Tirana. University teachers for the course are being trained abroad.

About 500 primary care doctors and 1800 primary care nurses and midwives have undergone short retraining courses with support from the European Union PHARE programme. However, Albania does not have a professional accreditation system and no continuous training mechanisms are in place.

The Chamber of Physicians, created in 1993, is responsible for registration and professional standards, but it is extremely rare for doctors to have their

licence revoked. The Chamber needs to strengthen its role in promoting professional ethics and in advising on professional education and practice standards.

Albania had 1.3 doctors per 1000 population in 1997 (Table 9). This was low compared to the central and eastern European average of 2.5 in 1996 and the European Union average of 3.5 *(23)*. Albania has one of the lowest ratios of physicians to population in Europe (Figs 8 and 9).

There were 4759 doctors in 1995, and of these 1714 (36%) were primary care physicians, whose salaries were paid by the Health Insurance Institute *(9)*.

Table 9. Health care personnel, Albania, 1980–1997 (per 1000 population)

	1980	1985	1990	1991	1992	1993	1994	1995	1996	1997
Physicians	1.36	1.36	1.37	–	–	1.42	1.31	1.41	1.41	1.30
Dentists	0.25	0.32	0.34	–	–	0.39	0.40	0.35	0.32	–
Certified Nurses	–	–	–	–	–	–	4.51	3.89	–	3.71
Midwives	–						0.59			
Pharmacists	–	0.33	0.36	0.38	0.39	0.40	0.41	–	–	–
Physicians Graduating	0.06	0.03	0.05	–	–	–	–	–	–	–
Nurses Graduating	–									

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

Nurse training

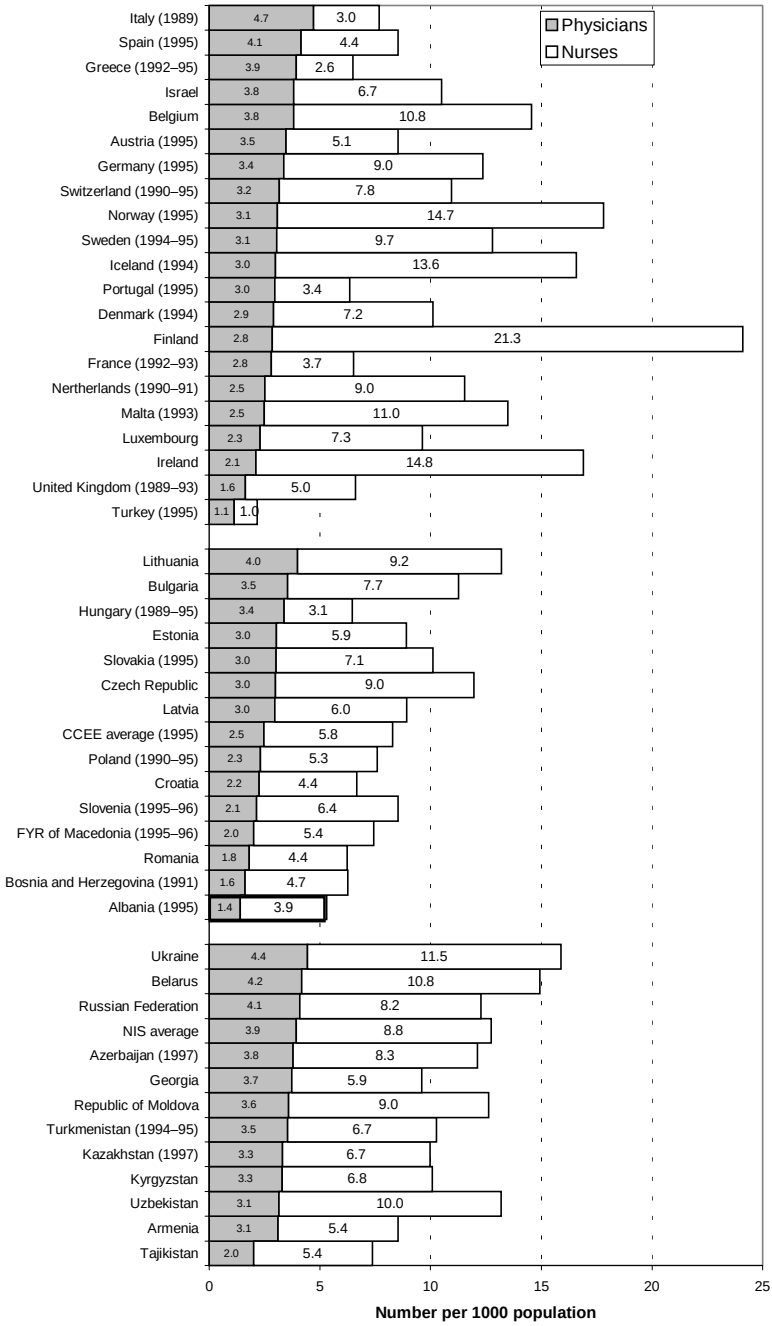
Before World War II, no nurses were trained in Albania. Nurse training was then offered as a two- or four-year course at high school level. Apart from general nursing and midwifery, there was little formal specialization, and any additional training was carried out by the employer.

Nurse education has now moved to post-secondary colleges. In 1994, the first Faculty of Nursing was created in Vlorë and a College of Nursing was also established in Tirana. Other colleges have opened in Elbasan and Korçë. Nurses are being trained to teach in these post-secondary courses.

There is no professional body for nurses or midwives, and professional self-regulation for nurses has not yet developed in Albania.

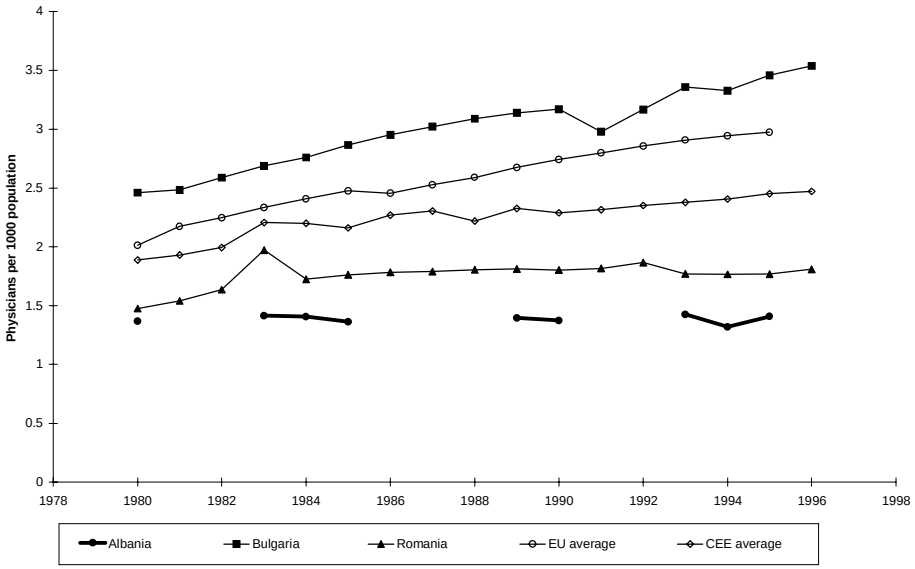
There were 3.7 nurses per 1000 population in Albania in 1997 (Table 9). This was well below the central and eastern European average of 5 nurses per 1000 population. Albania is among the group of European countries with a

Fig. 8. Number of physicians and nurses per 1000 population in the WHO European Region, 1996 or latest available year



Source: OECD health data 1998; WHO Regional Office for Europe health for all database.

Fig. 9. Physicians per 1000 population in Albania and selected countries, 1980–1996



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

low ratio of nurses to population (Fig. 8). In 1995, Albania had 16 250 nurses and midwives *(9)*, and this count includes feldshers who were formerly categorized as ancillary staff.

The salaries of health professionals are very low. This is unlikely to change in the short term and has an adverse effect upon motivation and morale. Nurses in Albania are often treated as "second-class citizens" in comparison with physicians. Upgrading nurse education to university level, and involving nurses in the teaching process, is expected to bring positive changes in this regard.

Other training

Albania has a shortage of personnel with knowledge and technical skills in research, policy and planning, and health administration. There are no non-medical professionals, such as health economists or health promotion specialists.

Medical practitioners also need training in health system management. There is no tradition of health sector management in Albania and hospital directors are usually doctors with no training in management. Two parallel initiatives

are under way. First, the World Bank and the Ministry of Health, after piloting six short-term training courses, will launch a six-month training course in health planning/management at the district level in September 1999, with a focus on primary health care. This course is under preparation through the support of the University of Montreal. USAID and the Faculty of Medicine are planning a second postgraduate training course in health management, starting in the year 2000, with the assistance of New York University. Also the University of Tirana proposes to develop a new field of study in public health management. The Faculty of Medicine has already started a postgraduate training course in public health.

Pharmaceuticals and health care technology assessment

The state pharmaceutical production companies (Profarma and the Antibiotics Factory) were on the verge of collapse in 1992 and lacked the funds to buy imported raw materials for production. Albania received some foreign aid and began discussions on privatising all or part of the industry *(9)*. So far, the Antibiotic Factory has been privatized but not Profarma.

The domestic pharmaceutical manufacturing industry produces a number of essential drugs. The importation of drugs has increased, however, and they are more expensive for consumers. Pharmaceuticals must be registered with the Ministry of Health before they can be sold in the country.

Pharmaceuticals account for a high proportion of health service expenditure in most former communist countries and thus are a high priority in health care reforms. In 1994, pharmaceuticals accounted for 23% of the health care budget in Albania compared to less than 20% in most western European countries *(23)*. But this is likely to be an underestimate as no figures are available on out-of-pocket payments by individuals.

A national pharmaceuticals policy, drawn up in 1993, has been partially implemented over the last few years. This contains a series of goals such as the establishment of Good Manufacturing Practice, the compilation of a national pharmaceuticals formulary, and the periodic updating and expansion of a restricted list of essential drugs.

In 1994, an essential drug list of 174 products was drawn up, adapted from the WHO essential drug list, and only pharmaceuticals on this list are reimbursed (either partly or wholly) by the Health Insurance Institute. The list was expanded to 273 drugs in 1996 and 278 drugs in 1997 *(12)*. Drug reimbursement

took three quarters of the Health Insurance Institute budget in 1995 (see earlier Table 5).

As at July 1997, only infants under one year old, invalids and war veterans received a full subsidy for essential pharmaceuticals. Other subsidies are based upon four therapeutic groups; for example, the first group includes drugs used for cancer and tuberculosis *(12)*.

Essential drugs for hospitals are purchased three months in advance on the basis of predicted needs. As funding is very limited, hospitals often run out of drugs before new supplies arrive, so that patients often must buy their medications from private pharmacies. Drug reimbursement by the Health Insurance Institute is not indexed to price changes and inflation so that pharmacists pass on the additional cost to consumers.

Private pharmacies (over 500) are well stocked and better managed. There is no shortage of essential drugs, but the lack of a good regulatory framework allows poor practices, even in private pharmacies, such as poor quality of drugs, drugs sold past their expiry dates and sales of unregistered drugs.

There are various policy proposals to improve cost effective pharmaceutical consumption. The first has been implemented now that health care facilities are responsible for purchasing consumables and drugs from their own devolved budget. Medical personnel need training in prescribing, both in order to prescribe the most effective drugs and to control costs. The Ministry of Health is developing standard treatment protocols supported by technical assistance from the World Bank.

Until 1992, Albania produced most of the vaccines used in its National Programme of Immunization (except for the polio vaccine) in the Institute of Hygiene, Epidemiology and Immuno-biological products. This production was performed in poor laboratory conditions and for that reason the Ministry of Health decided to cease producing them. Since then, all vaccines are supplied from UNICEF or are imported. The problem of quality control of imported biological products and drugs remains since the quality control capacities of Albania are weak.

Health care technology assessment remains to be developed. One proposal, not so far implemented, is that expensive technology should only be purchased after assessment by an expert national body.

Financial resource allocation

Third party budget setting and resource allocation

The financial allocation mechanism prior to 1990 was discretionary. Funds were allocated to institutions and districts on the basis of their historical budgets (according to budget line items such as salaries), and also involved political decisions rather than being based on a needs-based or output-based formula. There were no incentives for good financial management and little autonomy since funds were strictly earmarked. Hospital directors and physicians were obliged to make frequent visits to the Ministry of Health and to the Ministry of Finance to argue their case for funds and staff *(9)*. An annual budget is now agreed and ratified by Parliament at the start of the financial year. Funds are then allocated to the Ministry of Health and to local government and other bodies. There is no real separation of purchase from provision although this may change in future. In Tirana, a pilot project has begun to purchase primary health care services from the Health Insurance Institute.

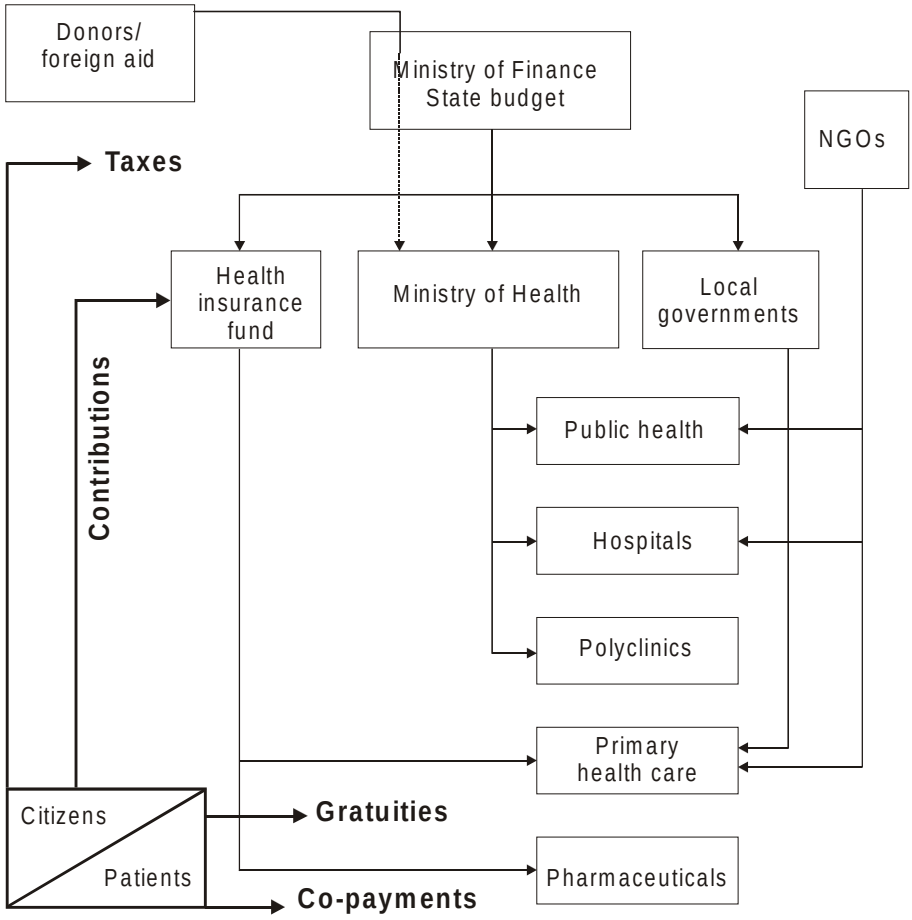
Payment of hospitals and institutions

The Ministry of Health allocates funds directly to hospitals with the budget earmarked for staff salaries and other recurrent expenses. Hospital directors negotiate their budgets directly with the Ministry of Health and have only limited discretion over expenditure.

Local governments are responsible for the infrastructure of the health centres and health posts, for operational expenditures and for nurse and midwife salaries, with the help of funds from the state budget.

Primary care doctors are now paid by the Health Insurance Institute.

Fig. 10. Financing chart of the health care system, 1996



The Health Insurance Institute will play an increasing role in financing health care provision. One key policy proposal is to expand the scope of the insurance fund to fund all primary care, then specialist outpatient care, and finally hospital inpatient care.

A second key proposal is the establishment of regional health boards. These would consist of representatives of local government, the local health team, the Ministries of Health and Finance and the Health Insurance Institute. These boards would be charged with planning and allocating resources within each region. A pilot project is expected to be implemented in the region of Tirana

with support from the World Bank and technical assistance from the UK Know-How Fund. At present, however, there are considerable legal obstacles in moving from a centrally controlled line item accounting system.

A third proposal is that managers of health care facilities should become more autonomous, with the authority to reallocate resources, control service quality and devise incentive schemes.

There are no proposals to move to other hospital budget systems such as a points system or diagnostic-related groups (DRGs). The latter type of budget system, however, is supported by the hospital doctors' lobby. The Health Insurance Institute is to pilot a case-mix budget system in two district hospitals in order to explore the advantages and disadvantages. The Ministry of Health views funding hospitals from the health insurance fund as a medium- to long-term strategy in Albania.

The Public Health Institute is funded through a separate Ministry of Health budget line, as are the other national institutes.

Payment of physicians

The salaries of primary care physicians have been paid by the Health Insurance Fund since 1995. The salary is based on a capitation amount for the number of patients enrolled with their practice, plus some weighting for the geographic area and type of patients. This capitation system is gradually being extended and a pilot scheme in Tirana is expected to fund primary care salaries from the insurance fund. In July 1997, the Health Insurance Institute paid capitation funds to 1 700 general practitioners in 721 health centres *(12)*.

All other physician salaries are based on national pay scales. Many physicians also receive under-the-table payments from patients, but the extent of these payments is not known. Physicians are not allowed to work in the public sector while also running private clinics.

Physicians are paid low salaries which remains a major source of contention. Primary care physicians paid by the Health Insurance Institute, however, are said to have increased their salaries by more than 50% *(11)*. They are now on a higher salary than some specialists on the national pay scale. The salaries of physicians and other health care workers need to be raised in order to discourage under-the-table payments.

Health care reforms

Aims and objectives

Albania began the transition from a centrally planned to a market economy in the early 1990s, as the poorest country in the European region with a long history of isolation. The dissolution of the communist model was accompanied by the collapse of its institutions, structures and mechanisms. This has meant that new systems had to be developed. The health care system has had the additional problem of severe constraints on government spending, given a shaky economy, continuing setbacks from civil disturbances, and urgent population health needs.

Although some reforms were begun before 1992, the Ministry of Health presented the main health sector reform proposals in June 1993 in a document called *A New Policy for the Health Care Sector*. This document was written in response to a paper produced by the World Bank in March 1992 highlighting the main strategies for health sector reform for Albania during the period of transition *(19)*.

There were two main objectives for health care system reform: first, to prevent further deterioration of basic services; and second, to move to a financially sustainable system that can be efficiently managed and produce effective services *(1)*. The basic goals expressed in the new policy document were as follows:

- to guarantee full access for the population to all preventive and most curative care at an affordable price;
- to give priority to those forms of health care that offer the best chance of improving health at the lowest price;
- to base the health system on a foundation of primary health care;
- to introduce market elements in financing health care;
- to give more managerial autonomy to districts and to create health regions.

The most important components of the reform can be summarized as follows:

- Streamline health services. The aims were to maintain and rationalize the network of primary health care facilities; transform the "rural hospitals" into outpatient health centres; maintain a network of district hospitals offering four basic health care services; upgrade a few district hospitals to the level of regional hospitals offering 10–12 specialized services; and to reorganize national level facilities into a unified University hospital.

- Improve the quality of health services through the rehabilitation of its infrastructure and the renovation and standardization of medical equipment; introduce a family medicine service and allow patients to choose their own doctor.

- Protect and increase financial resources for the health services. This would be done by protecting and increasing the public budget for health; by the introduction of private services, especially for dentistry, pharmacies and outpatient services in the short term, and hospital services in medium term; by the introduction of a careful scheme of health insurance; by privatization in parallel with the strengthening of the regulatory capacities of the Ministry of Health and other organizations, such as the Order of Physicians.

- Human resource rationalization and development. The aims were to reduce the surpluses in health sector personnel; reduce the number of students in the faculty of medicine; review the curriculum of the medical school and standardize postgraduate training; upgrade basic training of nurses to a three-year university degree; introduce a mechanism of regular continuous training; introduce new postgraduate training courses in family medicine; and introduce public health and health management.

- Decentralize and regionalize health services.

- Implement a new pharmaceutical policy through adoption of a new formulary for drugs; introduce a drug registration and licensing procedure; privatize the drug production industry; introduce subsidies for essential drugs sold in private pharmacies; and improve quality control of imported drugs.

- Strengthen and improve statistics and health information.

- Maintain and strengthen the existing public health programmes such as health education/promotion, mother and child, and HIV/AIDS prevention and control; and introduce new programmes such as family planning, hepatitis control and a safe blood system.

Reform implementation

The health sector reform launched in 1992 found varying degrees of support from different stakeholders, such as the government, parliamentarians, health providers and the population. This made it possible to implement successfully some key elements of reform as follows: the privatization of pharmacies and dentistry services; the introduction of private medical practice; an autonomous health insurance fund managed by the Health Insurance Institute; the transformation of most rural hospitals to outpatient clinics; the reorganization of national health care service in a unified university hospital; more managerial autonomy for district health administrations; subsidies for the national essential drugs list; the creation of mechanisms for drug registration and licensing; the start of postgraduate training in family medicine; the upgrading of basic training of nurses to a university degree, the introduction of family planning programme; the introduction of mandatory vaccination against hepatitis B for all newborn babies; and the systematic control of all blood donation for hepatitis B and C as well as HIV.

Many reform elements, however, were only partially implemented, or could not be implemented at all. This was for a variety of reasons including the weak capacities of the Ministry of Health and its structures, resistance from some interest groups, and also political reasons. The failures include the following. The Ministry of Health was not able to define the national map of the hospitals and their respective geographic and functional category (district or regional). The regulatory framework for private services was not completely defined and effective public control mechanisms were not set up. Postgraduate training in health management, public health and family medicine are facing serious difficulties. The continuous training courses launched by several donor agencies may not be sustained. The infrastructure and equipment of health facilities, despite investment by the Government and donors, is still sub-standard and the quality of service is very poor. The governance and regulatory capacities of the country are weak. Moreover, neither patients nor providers are satisfied with the present health system.

The Ministry of Health is reviewing the present status of the health sector in order to define the future direction of its health policy. This was the objective of the National Conference of Public Health organized in January 1999 by the Ministry of Health with the cooperation of WHO. The process is still ongoing and the Minister of Health expects a new policy paper by October 1999. Current political instability in the Balkans and the refugee crisis in Albania, however, make this commitment unrealistic.

The reform of the health care system will continue. Sources of finance for the health sector will be diversified. There are no plans, however, to radically privatize health care funding or provision. The state will continue to finance institutions, such as public health facilities, and to finance the capital costs of health services. The Health Insurance Institute will play an increasing role in funding direct service delivery. For instance, the health insurance fund is expected to purchase all primary care services, starting in the Tirana region on a pilot basis. Based on this experience, purchasing is expected to be extended to other districts.

Resource allocation within the health service is also planned to change. Health insurance will play a greater role in funding both outpatient specialized care and hospitals. This will require a new system of reimbursement based on contracts. The Health Insurance Institute, with the assistance of some foreign organizations, is preparing a series of studies but the mechanisms for the purchase of service contracts have yet to be determined.

The number of hospital beds has been reduced by closing small substandard hospitals. These facilities were not really functioning as hospitals. They contained about 15–20 beds and a few health care professionals but no diagnostic or laboratory facilities.

Decentralization has been limited because the Ministry of Health retains control of secondary and tertiary health care. The directors of health care facilities have little autonomy and there are few incentives for more cost-effective management.

Local authorities are expected to have limited control over the daily management of health services and their operational resources. The planning and managerial capacities of these local authorities are very weak and their accountability is almost non-existent. Regional and district health boards, with representatives from local authorities, may be set up in order to advise on local policies and plans. A new regional health authority will be established in Tirana first, before being implemented in the rest of the country.

Information requirements will need to be identified and information systems set up to meet these needs. Standard setting and regulation under a less centralized system also requires the development of other stakeholders, such as an independent chamber of physicians and organizations that can advocate on behalf of patients' rights.

Current health policies propose separating the regulation of the health care system from its financing and service delivery. This would restrict the Ministry of Health role to the regulation, monitoring and enforcement of normative standards for institutions and health professionals. Resource allocation decisions would be transferred from the central state to the Health Insurance Institute

and to local health boards, except for major capital investments. Under this scenario, the central state would no longer be able to exert policy control through its power over funding. Such a major change would require many political and legislative decisions.

Conclusions

Albania is embarking upon reforms to its health sector but it is greatly hampered by a struggling economy and outbreaks of civil unrest. Nevertheless, the country has the advantage that its population enjoys reasonable health according to key measures such as life expectancy. Furthermore, Albania established good access to primary health care services at village-level under the previous communist regime.

A prerequisite for any functioning health care system, however, is peace and stability. Moreover, the state must have sufficient economic means to take responsibility for health care. Albania's health care system must be evaluated against the country's generally low level of economic development and the absence of long-term stability. One clear lesson from recent events is how rapidly civil unrest can destroy both health facilities and the delivery of services. Despite the widespread collapse of the health care system in early 1997, the system had begun functioning again by early 1998. From March 1999, however, the Albanian health care system was called upon to respond to many thousands of ethnic Albanian refugees from Kosovo fleeing across the border from Serbian attacks. The effects of this tremendous crisis are difficult to foresee at present.

The Ministry of Health has yet to develop a strong policy and planning role, which is crucial if the country is to manage the increasing demands being made upon its under-resourced health care system.

The Health Insurance Institute can be judged a relative success, with the fund in surplus in the first few years of its operation. Some groups, such as farmers and to a lesser extent other self-employed, are not making insurance contributions, which has a negative effect on the equity of health care revenue. The lack of a broad base for contributions and difficulties in collecting payroll taxes (including insurance contributions) may impede plans to extend health care financing through insurance.

The relatively slow pace of change in the finance and organization of health care has helped preserve some stability in difficult times. The Ministry of Health has proceeded with some rationalization of the hospital sector, which is likely to improve efficiency. Further improvements in efficiency will require the development of managerial skills through training of hospital directors and through devolving increasing budgetary responsibility to regions or to hospitals. Management has to be decentralized in order to improve accountability.

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

It is difficult to judge the effect of health care reforms on health gain. For instance, the liberalization of abortion has decreased the maternal mortality ratio but the number of abortions has increased dramatically because family planning is not yet developed. Until recently, Albania had a good record of childhood immunization but the outbreaks of measles in 1990 and polio in 1996 revealed the fragility of the immunization programme. In addition, this capacity has been damaged during outbreaks of political conflict. Similarly, the public health system was effective but still lacks the capacity to respond to rapid lifestyle change in the country, which will impact upon the morbidity and mortality of Albanian citizens.

Albania's health care system, like the country as a whole, is facing huge challenges. The basic infrastructure for health care delivery has been maintained, despite the difficulties, and is being reorganized in a rational way. The success or failure of the Albanian health care system remains dependent on the country's continued stability and on its economic recovery.

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Appendix 1

1992 Council Of Ministers' Decree No. 449 Reorganization of the Health Services in State Enterprises.

1992 Law No. 7643 on the State Sanitation Inspectorate.

1993 Law on Environmental Protection

1993 Law No. 7692 Supplement to the Constitution, chapter on human rights

1993 Order of Physicians. (Compulsory registration of physicians)

1993 A New Policy for the Health Care Sector. Ministry of Health policy document

1993 Law No. 7718 on Health Care. (Abolishes right to universal free health care)

1993 Decree No. 325 Import/Export and Wholesale Trade of Drugs and Medical Supplies

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

1993 Law No. 7738 on Health Care. (Guidelines for payment of dental services and on health insurance schemes).

1993 Law No. 7815 on Drugs (regulating drug control and reimbursement on essential drug list).

1994 Law No. 7835 on Autopsies

1994 Law No. 7850 on Health Insurance (reimbursement on drugs and for general practitioners)

1994 Law No. 7975 on Narcotics and Psychiatric Drugs

1994 Law No. 8025 on Prevention from Ionizing Radiation

1995 Law No. 8045 on Medical Interruption of Pregnancy (criteria for legal abortions)

1995 Law No. 7941 on Food (respective Ministerial responsibilities on quality and distribution).

1996 Law No. 8092 on Mental Health (care for and rights of psychiatric patients).

Source: Ministry of Health & Environmental Protection of Albania & WHO 1996, Annex 4.