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Ertila Druga

The Health Care System in Albania

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1. Country Overview

Source: On The World Map 2021

- Sub-Region: Southern Europe
- Capital: Tirana
- Official Language: Albanian
- Population size: 2,878,000 (United Nations 2020)
- Share of rural population: 38.8% (United Nations 2019)
- GDP: US$15,278 billion (World Bank 2019)
- Income group: Upper-middle income (World Bank 2019)
- Gini Index: 33.2 (World Bank 2017)
- Colonial period: n/a
- Independence: 1912 (Declaration of Independence from the Ottoman Empire)

1. Selected Health Indicators

Indicator	Country	Global Average
Male life expectancy at birth (2018)	76.8	70.4
Female life expectancy at birth (2018)	80.2	74.9
Infant mortality rate (per 1,000 live births) (2019)	8.61	28.23
Maternal mortality rate (modelled estimate for 100,000 live births)	5.8 (2011)	211 (2017)
HIV prevalence among adults aged 15-49 (2019)	<0.1%	0.7% [0.6-0.9%]
Tuberculosis prevalence (Rate per 100,000 population) (2019)	16 (14-19)	100 (89-110)

Source: (The World Bank 2020, UN 2020, WHO 2020)

2. Legal Introduction of the System

Name and type of legal act	On the Organization of Public Health Services
Date the law was passed	June 16, 1927
Date of *de jure* implementation	July 16, 1927

Brief summary of content	Establishment of the General Directorate of Public Health (GDPH) as the highest institution in the country, responsible for organising, regulating, and drafting the public health care services budget. The law set up the hierarchical structure from the centre to the prefectures and municipalities and defined the rights and obligations of the health care personnel (doctors, pharmacists, dentists, nursing staff and health administration). It introduced state support in financing care for the poor, guaranteeing them free medicines and health service provision.
Socio-political context of introduction	Until the eve of the twentieth century, Albania was part of the Ottoman Empire. The early state-building efforts after gaining independence on November 28, 1912, were shattered by the Balkan wars and the Great War. The government established the GDPH, an autonomous body within the organizational structure of the Ministry of Interior Affairs but under the charge of the Prime Minister.[1]

Source: Official bulletin of the Republic of Albania. No. 56, July 08, 1927, p 1-10.

3. Characteristics of the System at Time of Introduction

a. Organizational structure

» Centralization of health care system: Efforts were made to centralize the regulation and financing of health care under the GDPH, although the municipalities maintained control and management over the health care services. The latter were provided by doctors at district and municipal health centres, and ambulatory care in rural areas. They were appointed by the government and worked under the supervision of the GDPH. The existent hospitals – either military ones inherited from the Ottoman period or the new one built by the American Red Cross and those already operated by the municipalities – in addition to those built by the government, were centrally operated and financed by the latter.

» Eligibility: All citizens were eligible for health care services at health centres and hospitals, but the state only subsidized health care for the poor. Everyone else had to pay according to the fees and tariffs determined by the GDPH.

b. Provision

Health care Infrastructure		In 1937
General hospitals		8
Neuro-Psychiatric hospital		1 *
Hospital beds (1920-1930)[2]		810 (0.8 beds per 1,000 population)
Human resources for health	In 1920	In 1937
Doctors	50	155 (1.5 per 10,000 population)
Dentists	7	41 (1 per 25,000 population)
Pharmacists	25	49 (1 per 20,000 population)
Midwives	5	29
Nurses	0	20

Source: (Kucaj 2017; 2020)

1 General Directorate of Archives. Decision no. 1032 dated December 01, 1920.

2 At that time, the population was less than one million inhabitants. The Census for 1923 recorded 814,380 inhabitants and the Census for 1930 recorded 1,003,097 inhabitants. http://open.data.al/sq/lajme/lajm/lang/sq/id/669/Popullsia-ne-Shtetin-Shqiptar-1870-2011 Accessed February 01, 2021

c. Financing

- There is little information on health financing in Albania during this early period of state-building. In 1923, the government drafted its first annual budget for financing all hospitals throughout the country (Health Insurance Institute, 2012), and from 1925 to 1926 the annual budget for hospitals was consolidated (General Directorate of Archives 1938: 57). The data present these annual budgets in domestic currency, viz. Albanian golden francs (franga ari).[3]

d. Regulation

- *Actors responsible for regulation*: The GDPH was responsible for the organization of the health care services (1927). The set of regulatory laws included those on the obligation of doctors to serve in public service care for two years (1924)[4], regulations on the medical profession: doctors, dentists, midwives and pharmacists (1927[5]; 1928[6]), the Medical Association Law (1928)[7], on the continuing education of health workers (1927), and the Public Hospitals Law (n.d). (General Directorate of Archives 1938: 58).
- *Public service package*: In 1932, a special law on hospital charges (Health Insurance Institute 2012:11) was drafted. These payments depended on individuals' income - occupation or the type of business owned by the individuals.

4. Subsequent Historical Development of Public Policy on Health Care

a. Major reform I

Name and type of legal act	Law no. 3766 "On Health Care in the People's Socialist Republic of Albania"
Date the law was passed	December 7, 1963
Date of *de jure* implementation	December 7, 1963
Brief summary of content	The law aimed at the full involvement of the state in health provision and financing, and transformed the Albanian health care system into a Soviet Semashko model.
Socio-political context of introduction	Soon after the liberation of the country from the Nazi occupation, the General Directorate of Public Health was transformed into the Ministry of Health. The Communist Party and the newly established government started reforms for nationalizing all health facilities, equipment, and other assets. On July 11, 1946, the government decision to nationalise all medical practices equipment and materials, marked the first step towards the establishment of the Semashko system in Albania. On Sptember 18, 1950, the government adopted the decree on fee and tariff reduction, and with the 1963 law the services became free at the point of entry (CHIF 2012: 13-6).

b. Major reform II

Name and type of legal act	Law No. 7870 of October 13, 1994, On Health Insurance in the Republic of Albania
Date the law was passed	October 13, 1994
Date of *de jure* implementation	Mid-1995
Brief summary of content	Introduction of a social health insurance scheme to finance a list of reimbursement drugs and the payment of family doctors in the public system.

3 It varied between the amounts of 330 thousand up to 802 thousand golden franga per year. A more precise evaluation (conversion to other currencies) is missing (cit. Author)
4 *Official bulletin of the Republic of Albania. No. (missing), August 30, 1924, p. 2*
5 *Official bulletin of the Republic of Albania. No. 56, July 08, 1927, p 10-13.*
6 *Official bulletin of the Republic of Albania. No. 77, July 21, 1928, p 3-8.*
7 *Official bulletin of the Republic of Albania. No. 77, July 21, 1928, p 11-13.*

Socio-political context of introduction	The events at the beginning of the post-communist transition and the overall economic, political, and social changes forced the new democratic government in April 1992 to undertake systematic reforms in the health sector. In 1993, the 1963 law "On Health Care in the People's Socialist Republic of Albania" was abolished and the Albanian parliament passed Law no. 7718 (dated June 03, 1993) "on Health Care" and Law no. 7738 (dated July 21, 1993). This prepared the ground for introducing private medical practices, and the health insurance scheme (Nuri 2002). On October 13, 1994, the adoption of the law on Health Insurance produced a paradigmatic shift in health care entitlements from universal health care rights to individual ones. From 1992 until 1996, major reforms in all dimensions of the health care system – service provision, financing, and regulation – were adopted.

c. Major reform III

Name and type of legal act	Law no 10833 On Compulsory Health Insurance
Date the law was passed	February 24, 2011
Date of *de jure* implementation	January 01, 2013
Brief summary of content	This law specifies entitlement to the Compulsory Health Insurance Fund benefits for economically active and inactive people. The basis for entitlement changed from residence to payment of contributions (Tomini and Tomini 2020).
Socio-political context of introduction	Until 2011, the health financing system was fragmented. The Ministry of Health paid for hospital care, non-physician salaries, and other operating costs for primary care, while the Health Insurance Institute (HII) paid for salaries of primary care physicians, prescription drugs, and high-end diagnostics. Financing responsibilities changed over the years, with local governments expected to cover operating costs for primary care. The Law of 2011 transformed the HII into a single-payer Compulsory Health Insurance Fund. It aimed at improving the mobilization and allocation of financial resources in the health care system while specifying entitlements, which are still in place today (CHIF 2013).

5. Description of Current Health Care System

a. Organizational structure

» *Centralization of the system:* During the last three decades of political and economic transition, the system was first decentralized and then recentralized.
The decentralization reform started in 1993 with the Law on Local Government that granted the communal governments control over all primary health care centre services in rural areas. Law No. 7718, on Health Care, permitted the Minister of Health to give more power over resources to districts (Nuri 2002:75). With respect to financing, the Health Insurance Institute (HII) was established in 1995 as a single purchasing agency. In 2011/2013, HII was transformed into the Compulsory Health Insurance Fund (CHIF), financed through a mix of payroll taxes and general tax revenues (CHIF 2018).
The decentralization process continued further in the early 2000s, with the Council of Ministers' decree creating Regional Health Authorities. The pilot project of Tirana Regional Health Authority combined a regionalized approach and a decentralized purchaser-provider model. Another decree on financing Durres regional hospital by the HII allowed more autonomy and created another decentralization model at the secondary level of service provision (World Bank 2006:109-11).
In 2018-2019, re-centralization efforts and the organizational reform of service provision established the Health Services Operator[8] under the authority of the Ministry of Health and Social Protection as an intermediate level of governance between the central level and 36 public health directorates that are currently in charge of the provision of health services in 61 municipalities.

8 Decision of Council of Ministers no. 419 of July 04, 2018, on Establishing, Organizing and Governing of the Operator of the Health services. Accessed on February 15, 2021. http://oshksh.gov.al/wp-content/uploads/2019/06/rregullorja-e-operatorit-1.pdf

- *Eligibility/entitlement:* In 2013, the basis for entitlement changed from residence to payment of contributions. The 2011 law[9] specifies that membership in the CHIF is mandatory for employees and other economically active persons, who must pay contributions to the tax authority to obtain CHIF benefits. The Government transfers funds to the CHIF to cover economically inactive people such as children aged under 18 years, students under 25 years, pensioners (retirement age is 65 years for men and 60 for women), people registered to receive social assistance or disability benefits, registered unemployed people, asylum seekers and a few other categories set out in special laws. CHIF membership is voluntary for self-employed people, small family businesses and farmers. Uninsured people are entitled to free emergency care (since 2013), a free annual basic health check-up (since 2015), and free visits to GPs (since 2017) (CHIF 2013; 2016; 2017; 2018).
- *Segmentation by population group:* The right to equal health care is embedded in the Albanian Constitution. Article 55 states that "*Citizens enjoy in an equal manner the right to health care from the state*" and grants everyone the right "*...to health insurance in accordance with the procedure provided by law*".[10] However, the 2011 law produced a two-tier system of access to health care. Those unable to receive CHIF benefits tend to be informal workers, poor people, minorities (Roma people), and people living in deprived areas (rural and peri-urban areas). These groups may face further disadvantages if they are not fully aware of their entitlements or encounter difficulties navigating the health system (Tomini and Tomini 2020).
- *Coverage*: According to a World Bank estimate (2015:2), only about 61 percent of the population (and half of the poorest quintile) is covered by social health insurance. A recent study claims that the CHIF covers only two-thirds of the population (Tomini and Tomini 2020).

Percentage of population covered by government schemes	N/A
Percentage of population covered by social insurance schemes	61%[11]
Percentage of population covered by private schemes	N/A
Percentage of population not covered	39%[12]

b. Provision

Indicator	Value	Source
Physicians (per 1,000 inhabitants)	1.21	World Bank Data (2016) *
Nurses and midwives (per 1,000 inhabitants)	3.65	World Bank Data (2016) *
Hospital beds (per 1,000 inhabitants)	2.89	World Bank Data (2013) *

* Data are from the World Health Organisation, supplemented by country data.

9 Law 10383 dated 24 February 2011 took effect in 2013. It guarantees entitlement to CHIF benefits for economically active and inactive people.

10 Constitution of the Republic of Albania. The Albanian version can be retrieved here. https://qbz.gov.al/preview/635d44bd-96ee-4bc5-8d93-d928cf6f2abd. The English version can be retrieved here https://www.osce.org/files/f/documents/3/2/41888.pdf

11 This is an average estimation provided by the World Bank (2015:2)

12 This average estimate is calculated by the author of this report.

c. Financing

Indicator	Value
Total expenditure for health (in % of GDP)	5.3
Domestic general government health expenditure (% of current health expenditure)	54.0
Domestic private health expenditure (% of current health expenditure)	44.7
Out-of-pocket expenditure (% of current health expenditure)	44.6
External health expenditure (% of current health expenditure)	1.4

Source: World Bank Data (2018). (World Health Organisation, Global Health Expenditure database (apps.who.int/nha/database).

Government health expenditures include the funds from the state budget and the contributions from social health insurance. In 2015, the latter comprised only 27% of government health expenditures (CHIF 2016: 15).

d. Regulation of dominant system

» *Actors responsible for regulation and governance:* The Ministry of Health and Social Protection plans health policies and strategies. It is also responsible for preparing the guidelines for accreditation and quality control and regulating activities in the sector.
Several independent regulatory bodies have been established. The National Agency for Medicine and Medical Supplies handles medicine control. The National Centre for Quality, Safety, and Accreditation of Health Institutions, approved in September 2005, is the only national body responsible for accrediting all public and private health care institutions.
As for regulation of providers, it is required that the respective professional bodies license their members. The Albanian Order of Physicians, established in 1993, has assumed responsibility for professional standards and the registration of doctors.[13] The National Centre for Continuing Education of health care professionals administers the national register of professional certifications.

» *Public service package:* The publicly financed benefits package is defined by CHIF and includes services provided by a mix of public and private primary care centres, hospitals and contracted providers of medicines, medical products, and others.
Primary care centres are contracted to provide emergency care services for children and adults, services for women and reproductive health, services for older people, mental health services, health promotion, and health education (CHIF 2018). A free annual check-up for people aged between 35 and 70 became operational in 2015 (CHIF 2016).
Most diagnostic tests and paramedical services, inpatient care, and inpatient medicines in public facilities are free with a referral for people covered by the CHIF. Since 2014, newly included private inpatient care services are free with a referral. They are grouped into ten packages: dialysis, kidney transplantation, acute rejection therapy, definitive pacemaker placement, coronary angiography, angioplasty, valve interventions, congenital interventions, coronary bypass surgery, and cochlear implants for children with hearing problems. Access to publicly financed outpatient specialist care requires a GP referral (CHIF 2016; 2018).
Dental care is not covered for most adults. Children and young people aged under 18 years, students under 24 years, and people receiving social assistance are entitled to dental care in public facilities; these mainly offer preventive services (Beci et al. 2015).

e. Co-existing systems

» Private health insurance, which provides coverage for private health care services, is voluntary. Take-up of private health insurance is often part of the benefits package for employees of big corporations or privately paid by individuals with higher incomes. It is neither complementary nor supplementary. It does not exempt

13 See more https://www.urdhrimjekeve.org.al/images/dokumenta/ligj_nr_123_dt_25_9_2014_19324_um.pdf Accessed on May 05, 2021.

individuals from contributing to government health coverage programmes. Therefore, duplicating the latter, offering coverage for health services already included under government CHIF.

f. Role of global actors

- Since 1992, several external actors have been involved in health sector reforms in Albania. The list includes the World Bank, USAID, the Swiss Development Cooperation, Italian Cooperation, WHO, UNICEF and others.
  The focus of USAID, UNICEF, and the Swiss Development Cooperation has been on primary health care services and health promotion activities, while the World Bank, through its technical assistance programme, has been focused on health financing, CHIF, and strengthening the hospital sector.
- The World Bank remains one of the most important actors in the Albanian health care sector. Since the early 1990s, it has been actively involved in the health care reform processes relating to financing, service provision, and regulation through expertise, technical assistance, and financial aid and loans.
  The World Health Organization monitors issues on financial protection and sustainable health financing structures and universal coverage.
- Churches and other charities play a minor role in health service provision and financing.

g. List of additional relevant legal acts

- Constitution of the Republic of Albania, 1998, Art. 55
- 1993 Law No. 7692, On Fundamental Human Rights and Freedoms (supplements the constitution of 1976)
- 1993 Amendment of the Law no. 3766 On Health Care and Free Delivery of Medical Aid by the State
- 1993 Law No. 7738, On Health Care (guidelines for payment of dental services and for health insurance scheme)
- 1994 Law No. 7870 of October 13, 1994, On Health Insurance in the Republic of Albania
- 1994 Law No. 7850, On Health Insurance (reimbursement for drugs and GPs)
- 1994 Council of Ministers Decree No. 613, On the Status of the Health Insurance Institute
- 1995 Council of Ministers Decree No. 343, On Financial Coverage of General Practitioners by the Health Insurance Institute
- 2011 Law no. 10383 of February 24, 2011 A new law on Compulsory Health Insurance
- 2018 Decision of Council of Ministers no. 419 of July 04, 2018, on Establishing, Organising and Governing of the Operator of the Health services.

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