Albania: The Health Insurance Institute and pharmaceutical reimbursement

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Health care in Albania
Albania has a population of 3.58 million. This is one of the youngest populations in Europe, with an average age of 28.9 years.\(^1\) In 2005, total health expenditure was 6.6% of Gross Domestic Product,\(^2\) putting the country in line with the average for lower middle income countries. Albania’s health care system prior to this transition was characterised by strong central government control over all aspects of the system. This was based on the Semashko style, which in one manner reflected the relationship between countries in central and eastern Europe. A series of reforms were initiated in the mid-1990s, which included the decentralisation of primary care management, privatisation of the pharmaceutical sector and the establishment of the Health Insurance Institute (HII).

The government is the major provider of health care services. They are organised on three levels: (i) primary health care is provided at health centres and polyclinics; (ii) secondary health care is provided at districts hospitals (51 hospitals in 36 districts); and (iii) tertiary health care is provided at the University Hospital Centre (CHU) located in the capital Tirana, where more than one-fifth of the population lives.

The HII covers primary health care services, including general practitioner and specialist visits, as well as the reimbursement of a list of outpatient pharmaceuticals (‘positive list’). In contrast, hospital care remains under direct state administration. Established in 1995, it is an independent body funded by payroll tax contributions as well as contributions from the self-employed and farmers, and governmental budget contributions for the dependent (non-active) population.

Pharmaceutical distribution and reimbursement
Patients treated at polyclinics and health centres who require a pharmaceutical product receive a prescription and collect it from a private pharmacy. Private pharmacies procure products from private wholesalers. If the patient is insured (covered by the HII), the pharmacy will be partially or fully reimbursed for the price of the medicine. The patient pays the remainder out-of-pocket.

Under the HII there is 100% reimbursement of prescription drugs for children 0–12 months, people with severe disabilities, military veterans, old age pensioners, as well as patients with cancer, tuberculosis, multiple sclerosis, anaemia caused by chronic kidney failure, major thalasaemia, and kidney transplantation.

There is partial reimbursement ranging between 50% and 95% of prescription costs, dependent on therapeutic class for employees, the voluntarily insured, those with mild and moderate disabilities, social welfare recipients, children aged one year and over, students, expectant and new mothers and soldiers. The levels of reimbursement were last approved by the Council of Minister in February 2007. The percentage of reimbursement is calculated using a reference price which represents the lowest retail price of a generic drug (lowest CIF price\(^*\) + wholesale margin + retail margin). Moreover, military veterans can be prescribed any branded product (i.e. a registered drug, regardless of whether on the reimbursement list).

The current distribution margins in Albania are high compared to those of other countries - 18% for wholesale and 33% for retail. The current fixed margins create an incentive to distribute higher priced drugs. At the same time, a digressive margin system has been introduced for the most expensive drugs (about 20% of drugs on the reimbursement list), aimed at reducing this incentive to sell expensive drugs. For example, the drug Erythropoetinum ampoule, has lower margins of 8% for wholesale and 15% for retail, (the higher the price – the lower the margins). There remains however scope for informal payments to be potentially linked to prescribing practices as highlighted by the HII.\(^3\) There may also be perverse incentives for physicians and pharmacists to collude to process ‘ghost’ prescriptions, and then share the additional reimbursements received from the HII. A confidential telephone hotline has also been set up to allow the public to report instances where a patient has felt been pressurised to process their prescriptions in specific pharmacies.\(^3\)

The positive list and pharmaceutical expenditure
There are currently 341 drugs on the reimbursement list (that came into force on 1 April 2007), and some can only be prescribed under specific conditions or following approval from a specialist. In this case, the primary health care (PHC) physician completes a form in which he...

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\(^1\) Cost, insurance and freight price.
recommends the specific drug to a specialist, for example, Ibuprofen 400 mg. The specialist may, however, prescribe another drug, different to that prescribed by the PHC physician, for example, Voltaren 50 mg.

In principle, all drugs prescribed by specialist doctors have to be endorsed by a PHC physician. Often, patients can get confused when they receive a different brand than that prescribed by the specialist and which they desired to have. To avoid this confusion, some patients choose to visit the specialist first and afterwards go to the PHC physician to endorse the prescription. The pharmacists are allowed to substitute less expensive, branded and generic drugs. The positive list is updated every year by a committee set up by the Order of the Minister and is made available to PHC physicians by the HII.

Over the past few years, the HII has been facing the problem of growing pharmaceutical expenditure.

Expenditure on pharmaceutical reimbursement drastically increased during 2003 and 2004 (see Table 1). In 2004, HII expenditure on drugs was €28.9 million (3.66 billion Leke). This equated to 60% of total HII expenditure or 10.6% of total health expenditure (including all public and private spending on health).

The increase in expenditure is due to a combination of factors, including the expansion of the positive list and the new co-payment exemption. For example 72 new drugs were added to the list in 2004, many of which were very expensive. At the same time, the reimbursement committee decided that drugs for pensioners should be fully reimbursed. In 2004, the HII therefore ran up a deficit of €4.8 million, that increased to €8 million in 2005.

Another challenge in Albania is that physicians tend to prescribe expensive brand name drugs, which leads to high expenditure. As indicated in Table 2 out of the top ten reimbursed drugs by value, six are single source and these are also very expensive. Approximately 50% of expensive drugs in the reimbursement list are single source drugs.

**Challenges and measures for improvement**

As drug distribution in Albania has been problematic and partially undermined by corruption, the HII has introduced a number of measures intended to improve

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Table 1. Total Expenditure of Health Insurance Institute of Albania, 1995–2004 (€ millions)

<table>
<thead>
<tr>
<th>Year</th>
<th>Reimbursement of drugs</th>
<th>% of total HII exp</th>
<th>Doctors</th>
<th>Administration</th>
<th>Investments</th>
<th>Pilot project expenses</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>2.4</td>
<td>73.4</td>
<td>0.6</td>
<td>0.2</td>
<td>0.1</td>
<td>0.0</td>
<td>3.3</td>
</tr>
<tr>
<td>1996</td>
<td>6.8</td>
<td>68.2</td>
<td>2.5</td>
<td>0.5</td>
<td>0.2</td>
<td>0.0</td>
<td>10</td>
</tr>
<tr>
<td>1997</td>
<td>9.5</td>
<td>74</td>
<td>2.7</td>
<td>0.6</td>
<td>0.0</td>
<td>0.0</td>
<td>12.8</td>
</tr>
<tr>
<td>1998</td>
<td>14.1</td>
<td>74.9</td>
<td>3.4</td>
<td>1.1</td>
<td>0.2</td>
<td>0.0</td>
<td>18.8</td>
</tr>
<tr>
<td>1999</td>
<td>15.3</td>
<td>74.9</td>
<td>3.8</td>
<td>1.2</td>
<td>0.2</td>
<td>0.0</td>
<td>20.5</td>
</tr>
<tr>
<td>2000</td>
<td>13.5</td>
<td>70</td>
<td>4.2</td>
<td>1.4</td>
<td>0.2</td>
<td>0.0</td>
<td>19.3</td>
</tr>
<tr>
<td>2001</td>
<td>13.3</td>
<td>56.7</td>
<td>4.8</td>
<td>1.8</td>
<td>0.2</td>
<td>3.4</td>
<td>23.5</td>
</tr>
<tr>
<td>2002</td>
<td>13.4</td>
<td>47</td>
<td>6.9</td>
<td>2.4</td>
<td>0.6</td>
<td>5.2</td>
<td>28.5</td>
</tr>
<tr>
<td>2003</td>
<td>17.8</td>
<td>51.5</td>
<td>7.8</td>
<td>2.5</td>
<td>1.0</td>
<td>5.4</td>
<td>34.5</td>
</tr>
<tr>
<td>2004</td>
<td>28.9</td>
<td>60.2</td>
<td>8.7</td>
<td>2.8</td>
<td>0.8</td>
<td>6.8</td>
<td>48.0</td>
</tr>
</tbody>
</table>

*Source: Health Insurance Institute of Albania, 2005.*

Table 2: Top ten reimbursed drugs by value 2005

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

*Note: Single source drugs in bold. Source: Health Insurance Institute, 2005.*

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*The average annual exchange rate for 2004 was €1 = 126.5 Leke.*
the situation and contain costs. First, certain drugs can now only be prescribed under specified conditions. In mid-2006, there was a revision of the positive list and different approaches to control spending. The budget is individualised and differs according to historical spending and the number of war veterans and people with disabilities seen by the physician. Also, additional controls are in place at polyclinics and in pharmacies to prevent the generation of false prescriptions that in fact are not dispensed. Furthermore, important steps have been taken to improve transparency along the pharmaceutical distribution chain. The HII is also looking into establishing treatment guidelines for primary care that could then be used to monitor prescribing. These measures are in themselves insufficient to curb the rapidly increasing expenditure, thus the HII is continuing to introduce new elements, including twelve health economic indicators, in an attempt to improve both the quality of primary health care and the efficient remuneration of physicians. These are thus divided between two performance and ten quality indicators (see Box 1).

Conclusions

The Health Insurance Institute is committed to consolidating efforts to strengthen the management of the health insurance system. The measures introduced, including these health economic indicators, are only the beginning of a long and complex process. Remaining challenges include strengthening control in the market; increasing transparency in the various commissions that make decisions; and revision of the level of pharmaceutical distribution margins. The success of these efforts will depend greatly on the future organisational model adopted as well as on the improvements in the rules and management capacities of the health system.

**REFERENCES:**


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**Box 1: Health economic indicators**

**Performance indicators**

1. Thirteen medical visits per doctor per day (rural) and sixteen visits per doctor per day (urban), with consideration for special cases, for example, physicians working in mountainous areas.

2. 60% of people registered in each health centre should be covered by insurance. Currently only 40–45% of the population benefit from coverage under the mandatory health insurance system, indicating that the majority of population still pay for medicines out-of-pocket.6

**Quality service indicators**

3. Planning of patient visits (all visits will be planned for chronically ill patients) aimed at avoiding the long waiting time and towards better organisation of physician time.

4. Maintaining the percentage level of immunisations in accordance with national standards.

5. Improving the situation of chronically ill patients (aiming to monitor and keep under control the diagnosis of chronic diseases and reimbursement expenditures for these patients).

6. Obtaining direct feedback from the population (for example, patient questionnaires) at least twice per year. (This point has been largely neglected)

7. First time patient visits have to cover 60% of an area’s population (this aims for doctor to knows the epidemiologic situation at areas he/she works).

8. Child mortality rates to be under the average of the health centre (for each doctor these data will be compared with data of the health centre where he/she works, data of regional level/data of national level).

9. The average prescription value per diagnosis to be in the regional level (The regional average prescription value per diagnosis is considered as a benchmark).

10. Decrease the average prescription value per inhabitant by 5% (This value to be decreased up to 5% when compared with that of previous year).

11. Decrease in references given by PHC physician to the specialist doctors by 5%. (This requires more responsibility and professional skills of PHC physicians, who sometimes recommend patients to a specialist without having clearly motivated reasons).

12. Participation of the medical staff in continuing professional development.

**Source:** Health Insurance Institute, 2007.