

Primary health care in Albania: rapid assessment



WHO European Framework
for Action on Integrated
Health Services Delivery

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WHO European Centre for Primary Health Care
Health Services Delivery Programme
Division of Health Systems and Public Health



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Abstract

This report describes the main findings and recommendations of a rapid assessment of the current conditions of primary health care in Albania. Progress has been made to scale up preventive services for targeted populations. However, system barriers remain to hinder the transformation of primary health care into a family medicine-based model of care. Among other recommendations, the role of health practitioners needs to be revised and agreed with key stakeholders, clinical guidelines and protocols need to be updated, managers need to be empowered to make decisions related to tailoring policies into action and intersectoral actions need to be reinforced.

Keywords

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Contents

Abbreviations	v
Figures and tables	v
Acknowledgements	vi
Background	1
Methods	2
Main findings	3
People-centredness	3
Aligning patient health-care choices to health needs	3
Patients' engagement and community empowerment	3
PHC services	4
PHC organization	4
Scope of PHC, standardization of services and quality improvement	5
Preventive services	6
Coordinating PHC with specialized and secondary care	6
Diagnostic equipment	7
Infrastructure	8
Health system enablers	8
Governance, responsibility and authority	8
Human resources and funding	9
Continuing medical education, licensing, accreditation and quality regulation	9
Using information and communication technology	10
Recommendations	11
Improving people-centeredness	11
Strengthening PHC performance	13
Ensuring supportive health system enablers	15
References	17

Abbreviations

GP	general practitioner
NCQSAHI	National Centre for Quality, Safety and Accreditation of Health Institutions
PHC	primary health care

Figures and tables

Figures

Fig. 1	Overview of the European Framework for Action on Integrated Health Services Delivery	2
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Tables

Table 1	Policy recommendations for people-centeredness	10
Table 2	Policy recommendations for strengthening PHC performance	11
Table 3	Policy recommendations for health system enablers	12

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Background

Albania has a population of 2.8 million. The country is divided into 12 counties and 61 municipalities.

The Government of Albania gives priority to improving the quality of life and more equitable life within and between the counties, as stated by the national strategy for the control of noncommunicable diseases 2016–2020 (1). The Government also recognizes that strong primary health care (PHC) significantly contributes to achieving these goals. In this context, a national preventive check-up programme for people 40–65 years old was introduced in 2015 and later extended to people 35–70 years old in 2017 (1,2).

WHO initially assessed the national preventive check-up programme in April 2015, identifying potential challenges and alternative solutions to ensure the successful implementation of the programme. The assessment proposed a set of indicators for monitoring and evaluation of the programme (2). Two years later, in April 2017, WHO assessed changes in PHC in the context of implementing the national preventive programme for check-ups (3). The results of the mission indicated that the programme increased population attendance to PHC and contributed to raising awareness that PHC centres can be visited for early detection and prevention of health problems (3).

As an initial step towards universal coverage, free accessibility to preventive services for the entire population, including uninsured people, was introduced in January 2017. More recently, the Government of Albania is planning additional investments to develop and implement new PHC models of care that consider the needs of urban and rural populations.

In this context, the Minister of Health and Social Protection requested WHO support to develop new PHC models of care with a focus on family medicine. A WHO mission took place from 15 to 18 January 2018. The mission aimed to conduct a rapid assessment of current PHC conditions in urban and rural areas.

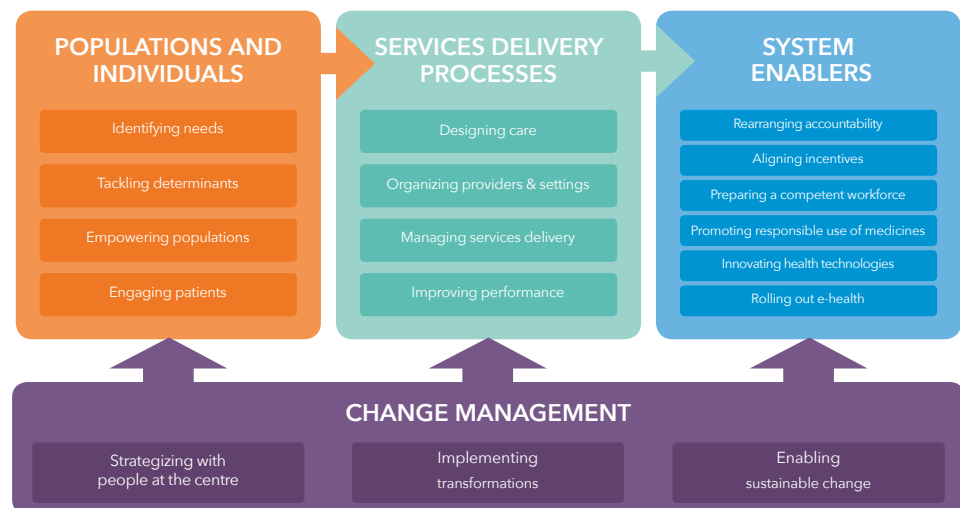
Methods

A team of experts on primary health care and health systems visited the country between 15 and 18 January 2018. The visit included bilateral meetings with managers and specialists of the Ministry of Health and Social Protection and national institutions responsible for accrediting PHC institutions and contracting and funding PHC services; bilateral meetings with regional public health authorities and with local government; site visits to selected urban and rural PHC facilities; a site visit to a polyclinic that provides secondary outpatient services; site visits to the admission department, consulting department, inpatient cardiology and endocrinology departments of the University Hospital and a final debriefing with the Ministry of Health and Social Protection.

During the site visits, semistructured interviews with managers, doctors, nurses and patients were performed.

The assessment was guided by the principles put forward by the European Framework for Action on Integrated Health Services Delivery and its approach to transforming health services delivery that is anchored in aligning four key domains: population and individual health needs; health services delivery processes; health system enablers; and change management (Fig. 1) (4).

Fig. 1. Overview of the European Framework for Action on Integrated Health Services Delivery



Source: Strengthening people-centred health systems in the WHO European Region: framework for action on integrated health services delivery (4).

Main findings

People-centredness

Aligning patient health-care choices to health needs

A strategic priority of Albania's National Health Strategy 2016–2020 is to strengthen a person-centred health system. The Government of Albania plans to invest in PHC to better address population health needs, including needs related to noncommunicable diseases. The Ministry of Health and Social Protection is strongly committed to make PHC more attractive for the population through appropriate services. As a result, the national preventive check-up programme has been implemented since 2015 to increase population attendance to PHC and to improve early detection of noncommunicable diseases and the associated risks. About 45% of the population 35–70 years old, who are eligible for the health check-ups, has been screened annually.

According to an assessment of the national preventive check-up programme conducted by WHO (3), population attitudes towards PHC have positively changed and the use of PHC for preventive services has increased. However, there is no systematic approach to follow up and manage patients with newly detected noncommunicable diseases. The population is not stratified by risk factors and morbidity levels. Patients outside the national preventive check-up programme have no access to the advanced laboratory and diagnostic equipment of the programme.

The need to improve population health choices to allow people to get the right services, at the right time and place and for the right outcome is an area for future improvement.

All PHC centres collect and report data that can be used for assessing health needs and setting priorities. The PHC centres report data on resources, morbidity and mortality monthly through district public health authorities to the Ministry of Health and Social Protection. Detailed assessment is needed on how the data collected are used for PHC-related decisions at the local, regional and national levels. PHC and public health professionals do not discuss data jointly for defining priority health problems in the community and for planning joint actions to address them.

The current role of local and municipal authorities in health needs assessment and in mobilizing the efforts of the health system to address the priority health needs of the population need to be better defined. Interviews with PHC administration and with district public health authorities revealed that local authorities have limited involvement in health needs assessment, policy decisions and health services.

Patients' engagement and community empowerment

Advanced methods for educating people with diabetes in the University Hospital were identified. Interviews with patients treated at the University Hospital confirmed that patients received proper education and are engaged in self-

monitoring and self-managing their conditions. In contrast, the schools for people with noncommunicable diseases are absent, and the individual motivational counselling services of the visited PHC facilities are limited to short single counselling sessions carried out by nurses.

The Swiss-funded Health for All Project is working in two pilot regions, Diber and Fier, with the aims of improving PHC services, of increasing community awareness on patients' rights and of promoting the best population choices for health and health care. Communities in the pilot regions are involved in defining health priorities.

PHC services

PHC organization

In Albania, PHC is organized through a public network of providers of health services. Each of the 61 municipalities has PHC centres with affiliated health post-ambulatories¹. On average, one PHC centre offers services to 8000–20 000 inhabitants, varying for urban and rural areas, registering a doctor:patient ratio of 1:2500 and nurse:patient ratio of 1:400 (5). All PHC centres are responsible for 24/7 duty. These services are not provided in all affiliated health post-ambulatories.

All PHC centres are under the direct supervision of the Ministry of Health and Social Protection, which recruits the medical and non-medical personnel and is responsible for investing in infrastructure and equipment. In most cases, the buildings and land are the property of the Ministry of Health and Social Protection or of the local governments. Each PHC centre has a chief physician, who is usually a general practitioner (GP).

The composition of PHC teams varies according to the centre. GPs specialize either in adults (15 years and older) or in children. However, in small rural areas, GPs provide services to people of all ages. Urban areas have paediatricians performing check-ups of healthy children and paediatricians caring for sick children. A similar division of labour applies to nurses. Nurses are often subspecialized, with a narrow scope of services.

The number of positions for doctors is in accordance with the population served. The visits revealed high variation in the number of doctors and even more in the number of nurses. This variation, both in quantity and profiles, cannot be explained by the size or the specific health needs of the population served.

In Tirana, the organization of the PHC centre includes diagnostic services staffed with specialized doctors, such as cardiologists, rheumatologists, orthopaedic surgeons, surgeons, obstetrician-gynaecologists and ophthalmologists.

The waiting time for an appointment with a GP is long, usually with queues at the doctor's door. PHC services are available during office hours, which vary from centre to centre depending on the number of GPs. The distance between PHC centres ranges from 10 to 25 km. This can comprise an obstacle for the population to visit GPs but also for the GPs to make home visits and/or to consult patients at more distant health post-ambulatories. GPs serve the population

¹ The term "health post – ambulatory" is used for everything affiliated with PHC centre facilities, since the name ambulator in Albanian is used for both types: (1) larger affiliated facilities with at least one general practitioner (widely used English term: ambulatory) and (2) small affiliated facilities with no doctors but only nurses available (widely used English term: health post).conditions.

on their lists and the schools located in the catchment area of the PHC centre.

The centres visited did not have vehicles. The condition of the roads and public transport availability within the areas with PHC centres influence the accessibility to PHC services, especially in winter.

Scope of PHC, standardization of services and quality improvement

PHC centres provide a scope of services defined by a basic package of PHC services adopted by the Ministry of Health and Social Protection in 2009 (6). The Compulsory Health Care Insurance Fund pays for all services included in the basic package of PHC services. The package defines seven groups of services: (1) emergency care; (2) health services for children; (3) health services for women of reproductive age; (4) health services for adults; (5) health services for older people; (6) mental health care; and (7) health promotion and education. In 2015, the groups for women of reproductive age and children were revised to bring them up to date with latest best practices.

According to the basic package of PHC services, GPs have to (1) manage primary health care; (2) focus health care on individuals; (2) solve special health problems defined in the seven groups of services; (3) provide holistic and integrated health care; (4) adapt services to fulfil community health service needs; and (5) provide basic check-ups for the people in targeted age groups as defined by Ministry of Health and Social Protection (6). The basic package also highlights the competencies of GPs in five fields: clinical responsibilities, managing the health risks in the population, communication with patients, managing the patients and managing health care.

Information on the participation of PHC professionals in clinical guidelines and protocols and patient pathways differs between sources. The assessment team concluded that PHC professionals insufficiently participate in developing clinical guidelines and protocols. The National Centre for Quality, Safety and Accreditation of Health Institutions (NCQSAHI) coordinates the development of clinical guidelines and protocols, but a standard procedure for developing clinical guidelines and protocols remains to be established.

During the visits to the PHC facilities, the assessment team found that quality improvement tools were implemented to a limited extent. During the interviews, the personnel stressed the need to be trained in PHC management. GPs share the same office with nurses. This creates constraints in the activity of both and does not enable the desired confidentiality and comfort for the patients during the consultation. Nurses are not involved in independent activities.

Preventive services

Preventive care and patient and family education are part of the basic package of PHC services (6). The description of preventive services is very detailed for monitoring the growth and development of children, who require frequent control visits during the first three years. Controls are then required once per year between four and six years of age. There are very detailed descriptions of tasks during the preventive visits, including implementing the national programme of immunization and monitoring nutritional status. This explains the high vaccination coverage.

Dedicated paediatricians and nurses responsible only for preventive services perform these services, which are organized as parallel services. In an urban PHC centre in Fier, a paediatrician covers 6000 children and provides only preventive check-ups, vaccination, preventive visits at home and prevention and management of child maltreatment from violence and abuse. This type of parallel services prevents a holistic assessment of child development and the detection of health problems, since it does not build on a trustful and continuous relationship with parents and teachers given the high number of children per paediatrician.

Preventive services for adults and their family are also comprehensively described for emergency care; adult care; women's health and reproductive health; and care for older people. Findings based on the site visits and interviews with doctors and nurses reveal that preventive services for women are organized separately, strongly focusing on pregnant women. Services for pregnant women are well supported with clinical guidelines and protocols. Early detection of cervical and breast cancer receives less attention. The basic package of PHC services recommends breast cancer screening annually for women older than 45 years and cervical cancer screening every three years (6). Cervical cancer screening requires a PHC gynaecologist referral to a regional or university hospital, with long waiting time. No systematic approach for identifying, inviting and following up the targeted population is in place.

In the context of the national preventive check-ups programme, rooms for preventive check-ups of adults in all PHC centres were renovated and provided with all the necessary modern equipment. Since January 2015, clinical guidelines and protocols for preventive check-ups (7) have been developed and practitioners trained. Despite the increased number of preventive visits to PHC, shortcomings remain regarding the scope of the tests provided, monitoring detected cases, the accessibility of tests for opportunistic screening to other age groups than the one targeted by the programme and the follow-up of newly diagnosed cases (3).

The director of the public health authorities of Fier district reported being in charge of 19 PHC centres and their 111 affiliated health post-ambulatories. To improve the links between public health services and primary health care, a department of general practice was established five years ago. Four public health specialists from this department are responsible for supervising PHC centres. These specialists and the managers of the primary health centres are responsible for preventive check-ups and health promotion in schools. Most of the 95 employees of the public health authorities of Fier district are specialists in microbiology, epidemiology and environment protection. Only one specialist is responsible for health promotion and education. It was reported that other public health authorities have also limited resources for health promotion and education and do not have general practice departments.

Coordinating PHC with specialized and secondary care

During the site visits to the PHC centres, GPs reported increasing patient flows since the national preventive check-up programme was introduced in 2015. Nevertheless, data were not provided on the proportion of the catchment area that has been in contact with a PHC centre or the proportion of self-referral to the emergency departments of hospitals and/or polyclinics. The visit to one of the four Tirana polyclinics and to the Mother Theresa University Hospital confirmed

that many patients are self-referred. The head of the emergency department for adults at Mother Theresa University Hospital estimated that self-referrals could comprise up to 85% of the total visits to the emergency department.

The assessment team identified the following shortcomings:

- regulations on prescribing medicines require frequent referrals to narrow specialists for decisions regarding the treatment plan;
- restrictions to prevent patients from self-referral to specialists or hospitals are ineffective;
- lack of trust of GPs and other PHC personnel by specialists and the population; and
- weak communication between GPs and narrow specialists.

Diagnostic equipment

The PHC centres have a considerable shortage of diagnostic and treatment equipment and no standard list of equipment. Each PHC centre therefore has different equipment. No electrocardiograph, otoscopes or ophthalmoscopes were present in the PHC centres visited during the mission. One centre had a functioning X-ray machine from 1918 that deserves a place in a museum. The interviews confirmed patients' poor access to laboratory services, especially in rural areas. Even for simple blood and urine analysis, patients have to go to polyclinics. Except for people coming for preventive check-ups, there have been no attempts to collect patients' blood samples at PHC centres or health post-ambulatories and transport them to centralized laboratories. Except in emergencies, the equipment purchased from the national preventive check-up programme is currently not allowed to be used.

The PHC centres are in charge of maintaining equipment. However, the outdated equipment, the lack of qualified specialists, especially at the local level, and the limited budget puts strains on ensuring equitable access in PHC.

Infrastructure

Most of the buildings housing the PHC centres and affiliated health post-ambulatories belong to the Ministry of Health and Social Protection. A few health post-ambulatories belong to municipalities, usually with greater investment in infrastructure.

During the visits, it was observed that buildings are mostly old although well maintained. Some premises have been recently renovated. Some buildings show damaged offices, with the ceiling covered with mould, without a heating and ventilation system. The offices were small and uncomfortable. Some offices accommodate three to five people, including the patient, the GP and one or two nurses. Medical records are kept in the same office. Reception desks, even in larger PHC centres, are rather small with no or small waiting rooms. Some PHC centres in rural areas do not have waiting rooms.

For most of the PHC buildings, a budget for repairs and maintenance has not been made available in recent decades. Some premises were built to become consultation offices, but most were built with a different initial purpose and later adapted to accommodate the PHC centres. In general, the classical buildings are more resistant and easier to rehabilitate and maintain but they are usually oversized. The accommodated type has more appropriate dimensions and smaller recurring costs but are older and less resistant.

There are no regulations and standards regarding the minimal conditions for health facilities according to their functionality and category.

Health system enablers

Governance, responsibility and authority

In accordance with international trends, the Ministry of Health and Social Protection is developing new national policies to increase the degree of autonomy of public hospitals. A higher degree of autonomy could provide opportunities for improving the quality of care and efficiency while attracting dynamic managers.

A corresponding development for PHC has not been observed. Management at the facility level – PHC centres and a polyclinic – remains centralized, and the expression “micro-management” was often used during the interviews. Although the municipal system governance for infrastructure and education is being decentralized, health is not fully embedded.

PHC centre managers interviewed described limited authority to make decisions on financial or human resource issues. However, the level of autonomy differs greatly among managers. More active managers appeared to be leading towards more patient-centred, quality-focused and cost-efficient PHC centres. Closer links to municipal or county authorities seemed to facilitate a certain degree of autonomy in the decision-making process that facilitates the resolution of problems closer to the communities.

Human resources and funding

The Compulsory Health Care Insurance Fund is the purchaser of services. Its budget is distributed as follows: 24% for PHC, 27% for other forms of outpatient care and reimbursement for medicines, 48% for hospitals, 2% for the national preventive check-up programme and 2% for administrative expenses. Although PHC budgets are described as capitated, the Compulsory Health Care Insurance Fund funds the PHC centres based on historical allocation and consumption. PHC managers have a low degree of autonomy and flexibility, which makes the system inefficient. Nevertheless, the Compulsory Health Care Insurance Fund expressed willingness to consider new funding mechanisms, including incentives, and to review the current model for preventive check-ups.

The number of posts for doctors and their salaries are aligned with the number of people served. The number of nurses does not correspond to population size and varies from centre to centre. Internal and external migration of doctors and nurses and, overall, the shortage of health workers are becoming key challenges in PHC. Because of the unequal distribution of personnel, one GP often serves 2000–2500 people.

Continuing medical education, licensing, accreditation and quality regulation

Health professionals are required to systematically update their knowledge and skills by earning credits based on a continuing medical education programme. Professionals choose courses from the list approved by the Ministry of Health and Social Protection. However, not all the physicians working in PHC centres have training in family medicine.

The NCQSAHI is responsible for quality assurance. The NCQSAHI functions include evaluating the quality of services, ensuring the safety of patients and accrediting health facilities, including those in PHC. The Ministry of Health and Social Protection approves the standards for accrediting health service providers. All providers need to be accredited every five years. However, no regulations are in place to motivate, obligate or penalize providers who do not comply. NCQSAHI provides support to facilities in preparation for accreditation. Based on regulations issued by the Ministry of Health and Social Protection, a quality coordinator should also be available at each PHC centre, except for rural facilities.

Using information and communication technology

An electronic prescribing system is in place. GPs have noted that this has reduced the administrative burden and increased patients' access to medicines. Nevertheless, this mission did not assess the accessibility to and affordability of medicines.

There is no integrated national information system nor electronic medical records. PHC data are collected and transferred to government agencies on paper. Even though information technology has started to be rolled out in the country, initiatives are still scattered and uncoordinated.

Recommendations

Improving people-centeredness

A community orientation, focusing on the population living in the catchment area of a PHC centre, should be enhanced. People's health needs should be better understood and accounted for in setting priorities for services. This can be achieved by improving the analysis of the data collected by PHC and public health authorities. Bottom-up approaches involving local authorities in assessing health needs and setting priorities should be strengthened. Addressing priority health problems requires improving the integration of individual and community interventions. Further assessment is needed to better define the recent role of and opportunities for district public health authorities and municipal authorities in this process.

Table 1. Policy recommendations for people-centeredness

Recommendation	Timeline	Stakeholders
Revise the process of data collection, analysis and feedback to enhance the assessment of the health needs of the population served by PHC	Medium term	Ministry of Health and Social Protection, public health authorities, PHC facilities, local authorities, patients' associations
Enhance the role of local authorities in intersectoral community health interventions, combined with individual interventions to tackle priority risk factors and determinants of health	Medium term	Government, Ministry of Health and Social Protection, PHC, public health authorities
Introduce schools for patient groups to improve disease self-management	Short term	Ministry of Health and Social Protection, PHC facilities, public health authorities, patients' associations
Introduce risk stratification of the population and a follow-up system for patients with noncommunicable diseases and risk factors for noncommunicable diseases	Medium term	Ministry of Health and Social Protection, PHC facilities, public health authorities

Strengthening PHC performance

Strengthening the role of PHC requires increasing the self-confidence of PHC professionals but also building the trust of specialists and the population in PHC.

Clinical guidelines and protocols for the most prevalent clinical problems need to be developed with the involvement of PHC GPs, nurses and patients' associations. Internal quality systems at the facility level also need to be improved. Complete management of diseases should be implemented in PHC. Referral incentives should be enforced for patients and professionals to reduce unnecessary referrals to secondary care.

Nurses could be trained to expand their scope of practice. New nursing competencies, duties and responsibilities should be developed with a core focus on monitoring risk factors for noncommunicable diseases, managing people with noncommunicable diseases and those at higher risk and promoting healthy lifestyles.

Even though PHC service conditions and hence staffing and equipment will continue to vary according to geographical and social settings, a unified national model of general practice will facilitate the development of a scope of services, their quality and relationships to second-referral specialists. It will be easier to govern the referral system and cost-efficiency is likely to improve.

Table 2. Policy recommendations for strengthening PHC performance

Recommendation	Timeline	Stakeholders
Involve PHC professionals in developing clinical guidelines and protocols, to increase confidence in PHC	Short and medium term	Ministry of Health and Social Protection, NCQSAHI, PHC and professional organizations
Set up internal quality improvement mechanisms at the facility level	Medium term	Ministry of Health and Social Protection, NCQSAHI, PHC and professional organizations
Increase capacity to manage chronic conditions at the PHC level	Short and medium term	Ministry of Health and Social Protection, Compulsory Health Care Insurance Fund, regions, PHC structures
Expand the role of PHC nurses, including developing new nursing competencies	Medium term	Ministry of Health and Social Protection, Ministry of Education, training institutions, PHC professional associations

Ensuring supportive health system enablers

There is a need to train PHC managers and gradually increase their degree of autonomy to make decisions on aspects under their responsibility – including managing budgets, human resources and infrastructure and improving quality.

The mechanism to pay PHC practitioners should be based on capitation, target achievement and fees for services, moving from the current model of historical budgets.

Regulations and standards for each category of PHC centre (urban, regional, rural and remote areas) should be adopted or updated and remote areas) should be adopted or updated.

Table 3. Policy recommendations for health system enablers

Recommendation	Timeline	Stakeholders
Comprehensively assess PHC facilities	Short term	Ministry of Health and Social Protection, Public Health Institute, selected PHC centres, local authorities, public health authorities
Increase PHC facility managers' autonomy	Medium and long term	Ministry of Health and Social Protection, Compulsory Health Care Insurance Fund, regions, PHC structures, training institutions
Assess the training needs of PHC managers and develop and implement health management training programmes	Medium term	Ministry of Health and Social Protection, Ministry of Education, training institutions
Revise the payment mechanisms for PHC providers to include capitation, risk and incentives for achievements	Medium term	Ministry of Health and Social Protection, Ministry of Finance, Compulsory Health Care Insurance Fund, regions, PHC structures
Design a national family medicine-based PHC model that addresses the needs of the populations of urban, suburban, rural and rural mountain areas, adjusting the structure and organization according to needs	Medium term	Ministry of Health and Social Protection, Compulsory Health Care Insurance Fund, regions, PHC structures
Strengthen nurse basic education and continuing medical education and revise their scope of practice to include prevention and counselling on healthy lifestyles	Medium term	Ministry of Health and Social Protection, Ministry of Education, training institutions, PHC professional associations

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