Palliative Care Needs Assessment for Albania

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for
Albanian Ministry of Health Palliative Care Task Force

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Albanian Palliative Care Task Force

This needs assessment has been developed in collaboration with and with the assistance of the Palliative Care Task Force. This task force was formed to advise the Albanian Ministry of Health on implementation of palliative care in Albania as part of the National Cancer Control Plan. The Task Force is a sub-committee of the National Cancer Control Board.

Members of the Task Force include:

Dr. Donjeta Bali          Pediatrician, Mother Teresa University Hospital
Dr. Stephen Connor       Open Society Institute, New York
Dr. Kristo Huta          National Association for Palliative Care, Albania
Ms. Irena Laska          Mary Potter Palliative Care Service
Mr. Vasil Miho            World Health Organization, Albania
Mr. Albert Nikolla        Director, Caritas Albania
Dr. Fatmir Prifti        Sue Ryder Albania
Ms. Rudina Rama           Sue Ryder Albania
Dr. Agim Sallaku,         Chief of Oncology, Mother Teresa Hospital
Ms. Blerta Skendaj        Open Society Assistance Foundation, Albania
Mr. Henrik Zotaj          Palliative Home Care Program (SOB)

Acknowledgements

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Executive Summary

There are numerous problems that have prevented the development of widely available palliative care in Albania. The main problem is the lack of resources for health care generally. There is a longstanding cultural taboo against telling patients their diagnosis or prognosis and until 1990 it was against the law to inform cancer patients of their condition. While morphine is available in limited forms it has been reported that there are very few physicians in the country who are authorized to prescribe opioids. There is widespread opiophobia and a general belief that morphine kills patients.

Palliative care began in Albania in 1993 with the establishment of the Sue Ryder Albania Hospice. The National Association for Palliative Care (NAPC) was established in 2003 and currently has 4 members (the existing providers). In 2007 the NACP joined the European Association of Palliative Care and in 2009 joined the Worldwide Palliative Care Alliance.

Policy Development

There remains a need to address and formulate policy for palliative care to develop in Albania. As discussed most current efforts are directed at planning for the inclusion of palliative care in the National Cancer Control Plan. However there is a need for palliative care to be developed for the whole country and for all diagnoses. The PCWG is concerned about this need and is starting with Standards to ensure that the broader needs are understood from the outset. The Parliamentary Commission for Health has also agreed to introduce legislative language in support of palliative care with guidance from the Palliative Care Working Group and with the results of legal analysis.

Opioid Availability

Opioid availability is a significant problem in Albania. Morphine is only available in 10mg injection form and in 10mg long acting tablets. Occasionally 60mg long acting MS is available but only for short periods of time. Fentanyl is available but too expensive to afford. Methadone is only available for injecting drug users as part of the HIV prevention program. A critical problem is that there are only 11 physicians who are trained and allowed to prescribe opioids in the country. Five of these are at the Sue Ryder hospice. Of the 2.5 kg quota for opioids for the country most is used for anesthetic purposes. Sue Ryder Albania uses 280 g of opioids in Tirana per year, mainly injectable.

There is no availability of Oramorph liquid morphine. The physicians working in palliative care in Albania can prescribe Morphine without dosage limitations, while general practitioners can prescribe morphine only with the recommendation of the oncologist and in limited dosage of no more than 100mg per day. The four palliative care programs had to work very hard to obtain special permission from the Ministry of
Health to be allowed to prescribe opioids. The Ministry will give a special license to prescribe opioids but they have been resistant to expand this authority. Outside of the approved palliative care providers, each district in the country has only one physician designated to prescribe opioids for all other patients.

**Education**

Education in palliative care and use of opioids is a critical problem. The Sue Ryder Hospice and the Mary Potter Team in Korce have been conducting training in palliative care. Sue Ryder, through a training program funded by Soros in 2000 has trained over 750 interdisciplinary team members, mainly in the central and northern part of the country. Mary Potter has been doing training for 3 years in the south and east of the country.

Palliative Care is not yet included in the medical or nursing curricula. The Ryder Albania program has introduced a 6-hour course on palliative care in the Faculties of Medicine and Social Work.

During 2007 – 2008 Ryder Care Albania and Mary Potter have trained palliative care physicians and nurses from the North region of Albania in the towns of Shkoder and Lezhe, Elbasan. In the Middle region of Albania, courses have been supported by Caritas Albania.

During 2007 – 2009, the Mary Potter team in Korce has trained all the doctors and nurses of the region in palliative care, pain and symptom control, organizing basic, post-basic and advanced level training.

The Mary Potter team has also organized residential courses with nurses from Korca and other regions of Albania financed by SOROS and LCM (Little Company of Mary). Palliative Care is now part of the curricula of Medicine, Nursing and Social Sciences faculties, although in the Medicine Faculty Palliative Care as a subject has a limited number of participants, as it is an elective.

There is a need to create a unified national curriculum/course for teaching basic palliative care. Each of the providers has developed their own teaching materials. They have agreed to work collaboratively to create and receive accreditation for such a training course.
Summary

- Albania has a small but dedicated group of health care activists that are committed to seeing the development of palliative care move forward.
- The Ministry of Health has approved a palliative care working group to prepare recommendations for consideration by the government as part of the development of the National Cancer Control Plan.
- The Parliamentary Health Commission is willing to introduce legislation to recognize palliative care in the health care system and to support Educational program development and improved access to oral opioids.
- Palliative care has been provided in Albania since 1993 but there is no source of funding and no recognition of palliative care as a specialty or sub-specialty.
- The total need for palliative care has been estimated at up to 1,975 patients per day and approximately 12,000 patients per year (including approximately 3,000 cancer patients). In addition at least twice as many family members will need support.
- Up to 40 palliative home care teams are needed for the country. There is an estimated need for 100 inpatient beds for stabilization and treatment of severe symptoms throughout the Republic.
- Essential medications for palliative care are difficult to obtain in the country and there are too few physicians that are authorized to prescribe opioids.
- There are no curricula, courses or training centers within the country for professionals to be trained or certified in palliative care though there has been quite a lot of ad hoc training by 3 of the current palliative care providers. There is also a proposal to create unified palliative care curricula.
- Health care resources are quite limited in Albania, particularly since independence was gained from the Soviet Union. Most patients have to pay something for their care even when it is fully covered.
- National standards for the provision of palliative care in Albania have been initiated and need to be adapted for Albania.
- A system for monitoring and evaluation of palliative care should be developed and implemented from the inception of palliative care delivery.
- Including palliative care in the health care system will help Albania move closer to compliance with European Union standards.

Recommendations

Policy

1. A legal/regulatory framework for inclusion of palliative care in the existing health care system is needed. The Parliamentary Commission for Health has expressed willingness to introduce legislation for this, however a legal analysis is needed to ensure that all obstacles and gaps are identified for inclusion in legislation.
2. The palliative care section of the National Cancer Control Plan needs to be completed and submitted for approval.

3. This comprehensive national needs assessment for palliative care should be expanded into a national strategic plan for palliative care in Albania that builds on the recommendations in the National Cancer Control Plan.

4. The government-sanctioned task force that has been formed to assist in the development of recommendations for palliative care in Albania should expand its scope to include non-cancer palliative care provision.

5. National standards for palliative care operation are needed. The palliative care working group will review recently drafted national associations standards.

**Medication Availability**

6. Policy on the provision of opioids and other essential palliative care medications needs to be clarified to eliminate inconsistencies in prescribing, dispensing, distribution, and use. Legislation and regulation related to narcotics should be reviewed and appropriate changes made that support improved access to opioids.

7. The number of physicians allowed to prescribe opioids needs to be increased. A standardized training program in pain assessment and treatment for physician prescribers is needed.

8. Essential palliative care medications that are on the WHO list of recommended medications but are not available in Albania need to be made available.

**Education**

9. A palliative care educational program and training center needs to be established using agreed upon and state accredited curricula.

10. Palliative care curricula needs to be introduced into professional school training for physicians, nurses, social workers, and psychologists and for post-graduates.

11. A program for teaching palliative care is needed for continuing medical education that is consistent with (9) above.

12. A program of public education about the importance of palliative care needs to be developed and implemented.

**Implementation**

13. A funding mechanism needs to be established to encourage the expansion of palliative care. Reductions in cost for hospitalization could be used to grow interdisciplinary palliative home care and palliative care should be included in the basic benefits package. An economic impact analysis is needed.

14. Gradual scale up of home care teams and inpatient units should be undertaken to meet the need identified in the strategic plan for palliative care.
Palliative Care Needs Assessment for Albania

Introduction

Palliative care began in Albania in 1993 with the establishment of the Sue Ryder Albania Hospice. The National Association for Palliative Care (NAPC) was established in 2003 and currently has 4 members (the existing providers). In 2007 the NACP joined the European Association of Palliative Care and in 2009 joined the Worldwide Palliative Care Alliance.

Aims of this Needs Assessment

At the request of the National Association for Palliative Care and in cooperation with the Ministry of Health, OSI agreed to conduct an overall assessment of need for palliative care that could be used as a basis for development of a national plan for implementation of palliative care. This needs assessment includes comprehensive data on the healthcare system in Albania, the country, the population needing palliative care, the workforce needs to deliver palliative care, and preliminary recommendations for implementation of palliative care services.

Target Audience

The primary audience for this needs assessment is the Ministry of Health in Albania, which is working initially on a National Cancer Control Plan that will include a section on palliative care. Also the leading health care institutions in Albania, policy makers, government officials and all other Ministries, legislators, scientists, public health officials, NGO’s and civil society organizations.

Methods

This needs assessment has been prepared by OSI’s International Palliative Care Consultant and the Chair of NAPC as part of OSI’s International Palliative Care Initiative with assistance from Open Society Institute Assistance Foundation – Albania, (Blerta Skendaj) and the National Association for Palliative Care of Albania (President, Dr. Kristo Huta and Secretary, Ms. Irena Laska). The work was conducted during visits to Albania on May 11-14, 2009, November 1-8, 2009, April 12-16, 2010, and June 27 – July 2nd, 2010.

Definition of Palliative Care

The assessment was based on the World Health Organization's (WHO) definitions of palliative care and pediatric palliative care (for the full definitions see Appendix A).
“Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care for children represents a special, albeit closely related field to adult palliative care. Palliative care for children is the active total care of the child’s body, mind and spirit, and also involves giving support to the family.” [1]

Palliative care is an approach to preventing and relieving suffering, and promoting quality of life for patients and families living with potentially life-threatening illnesses. The authors view palliative care as not just end-of-life care, but as care given throughout the illness experience.

Data Sources

This assessment has been created using the following sources:

- Health data from the Albanian Ministry of Health
- Operational data from the 4 existing palliative care providers [2]
- Palliative Care Needs Assessment for Armenia, by Stephen Connor, PhD & Hrant Karapetyan, MD [3].
- Palliative Care Needs Assessment for the Republic of Macedonia, by Ann Sturley, RN, DrPH & Blaso Kasapinov, MD [4].
- On-line research sites

WHO Public Health Model

Believing that palliative care should be accessible to all patients, the authors took a public health perspective to assess the situation in Albania. The modified WHO Public Health Model (Figure 2) was used to provide a framework for the study and for this report. A public health approach aims to protect and improve the health and quality of life of a community by translating new knowledge and skills into evidence-based, cost-effective interventions that will be available to everyone in the population who needs them. As palliative care is an integral part of care for all patients, and the most beneficial approach to care for patients with advanced disease, it is important that all countries integrate palliative care into their healthcare systems at all levels. [8]
Figure 2: WHO Public Health Model for Palliative Care

Stjernswärd et al 2007

Interviews Conducted

Interviews with the following individuals were conducted:

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Organization</th>
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<tbody>
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<td>1. Andi Dobrushi</td>
<td>Executive Director</td>
<td>Open Society Foundation for Albania</td>
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<tr>
<td>2. Dr. Anila Godo</td>
<td>Minister of Health</td>
<td>Ministry of Health, Albania</td>
</tr>
<tr>
<td>3. Dr. Arben Ivanaj</td>
<td>Dep Minister Health</td>
<td>Ministry of Health, Albania</td>
</tr>
<tr>
<td>4. Maria Villanueva</td>
<td>Country Liaison</td>
<td>IAEA PACT</td>
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<td>5. Irena Laska, RN</td>
<td>Director</td>
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<td>6. Dr Agim Sallaku</td>
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<td>8. Dr Alban Ylli</td>
<td>Director</td>
<td>Institute of Public Health</td>
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<td>9. Prof. Nikolla Civici</td>
<td>Director</td>
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<td>10. Dr. Fatmir Prifti</td>
<td>Executive Director</td>
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<td>11. Mr Henrik Zotaj</td>
<td>Director</td>
<td>Oncology Palliative Service (SOB)</td>
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<tr>
<td>12. Mr. Albert Nikolla</td>
<td>Director</td>
<td>Caritas Albania</td>
</tr>
<tr>
<td>13. Dr. Bardh Spahia –</td>
<td>Dep Minister Health</td>
<td>Ministry of Health, Albania (new)</td>
</tr>
<tr>
<td>14. Ms. Lorena Kostallari</td>
<td>Sr Ops Officer</td>
<td>World Bank</td>
</tr>
<tr>
<td>15. Mr. Vasil Miho</td>
<td>Staff</td>
<td>WHO Country Office</td>
</tr>
<tr>
<td>16. Zamira Sinoimeri</td>
<td>Staff</td>
<td>WHO Country Office</td>
</tr>
<tr>
<td>17. Dr. Anyla Bulo</td>
<td>Vice Dean</td>
<td>State Medical School</td>
</tr>
<tr>
<td>18. Dr Tritan Shehu</td>
<td>Member</td>
<td>Parliament (chair of health)</td>
</tr>
</tbody>
</table>
The Country

History [6,7]

Scholars believe the Albanian people are descended from a non-Slavic, non-Turkic group of tribes known as Illyrians, who arrived in the Balkans around 2000 BC. Modern Albanians still distinguish between Ghegs (northern tribes) and Tosks (southern tribes). After falling under Roman authority in 165 BC, Albania was controlled nearly continuously by a succession of foreign powers until the mid-20th century, with only brief periods of self-rule.

Following the split of the Roman Empire in 395, the Byzantine Empire established its control over present-day Albania. In the 11th century, Byzantine Emperor Alexius I Comnenus made the first recorded reference to a distinct area of land known as Albania and to its people.

The Ottoman Empire ruled Albania from 1385-1912. During this time, much of the population converted to the Islamic faith, and Albanians also emigrated to Italy, Greece, Egypt and Turkey. Although its control was briefly disrupted during the 1443-78 revolt, led by Albania's national hero, Gjergj Kastrioti Skenderbeg, the Ottomans eventually reasserted their dominance.

In the early 20th century, the weakened Ottoman Empire was no longer able to suppress Albanian nationalism. The League of Prizren (1878) promoted the idea of an Albanian nation-state and established the modern Albanian alphabet. Following the conclusion of the First Balkan War, Albanians issued the Vlore Proclamation of November 28, 1912, declaring independence. Albania's borders were established by the Great Powers in 1913. Albania's territorial integrity was confirmed at the Paris Peace Conference in 1919, after U.S. President Woodrow Wilson dismissed a plan by the European powers to divide Albania amongst its neighbors.

Albania declared its independence from the Ottoman Empire in 1912, but was conquered by Italy in 1939. Communist partisans took over the country in 1944. Albania allied itself first with the USSR (until 1960), and then with China (to 1978). In the early 1990s, Albania ended 46 years of xenophobic Communist rule and established a multiparty democracy. The transition has proven challenging as successive governments have tried to deal with high unemployment, widespread corruption, a dilapidated physical infrastructure, powerful organized crime networks, and combative political opponents. Albania has made progress in its democratic development since first holding multiparty elections in 1991, but deficiencies remain. International observers judged elections to be largely free and fair since the restoration of political stability following the collapse of pyramid schemes in 1997; however, there have been claims of electoral fraud in every one of Albania's post-communist elections. In the 2005 general elections, the Democratic Party and its allies won a decisive victory on pledges to reduce crime and corruption, promote economic growth, and decrease the size of government. The election, and particularly the orderly transition of power, was considered an important
step forward. Albania joined NATO in April 2009 and is a potential candidate for EU accession. Although Albania's economy continues to grow, the country is still one of the poorest in Europe, hampered by a large informal economy and an inadequate energy and transportation infrastructure.

**Geography** [6]

Albania is a country located in Southeastern Europe, bordering the Adriatic Sea and Ionian Sea, between Greece in the south and Montenegro and Kosovo to the north.

![Map of Albania](image)

The total land mass is 28,748 sq km and country ranks 144th in size, slightly smaller than Maryland, USA. The country has 362 km of coastline on the Adriatic Sea. The weather is mild temperate; cool, cloudy, wet winters; hot, clear, dry summers; interior is cooler and wetter. The terrain is mostly mountains and hills with small plains along the coast. Natural resources include petroleum, natural gas, coal, bauxite, chromite, copper, iron ore, nickel, salt, timber and hydropower. Twenty percent of the land is arable and there are problems with deforestation, soil erosion, and water pollution.

**The People** [6]

The population is 3,659,616 (July 2010 est.) though the World Bank estimate for 2008 was 3,143,291.
The median age of the population is 30.2 years and the age structure of the population is:

- 0-14 years: 22.6% (male 432,756/female 394,119)
- 15-64 years: 67.4% (male 1,264,177/female 1,202,671)
- 65 years and over: 10% (male 170,273/female 195,620) (2010 est.)

The country is strongly ethnic Albanian (95%) with few other ethnic groups: 3% Greek, and 2% other (Vlach, Roma, Serb, Macedonian, Bulgarian (1989 est.). Estimates of religious affiliation are limited in the past it was Muslim 70%, Albanian Orthodox 20%, Roman Catholic 10% though most of the population, due to the Socialist Period, do not describe themselves as religious.

Literacy rate is very high at 98.7% of those over 9 years.

Albania has an urban population percent of 47%

The Human Development Index (HDI) provides a composite measure of three dimensions of human development: living a long and healthy life (measured by life expectancy), being educated (measured by adult literacy and enrollment at the primary, secondary and tertiary level) and having a decent standard of living (measured by purchasing power parity, PPP, income). The HDI for Albania is 0.818, which gives the country a rank of 70th out of 182 countries with data.

**The Economy [6]**

Albania, a formerly closed, centrally planned state, is making the difficult transition to a more modern open-market economy. Macroeconomic growth averaged around 6% between 2004-08, but declined to about 4% in 2009. Inflation is low and stable. The government has taken measures to curb violent crime, and recently adopted a fiscal reform package aimed at reducing the large gray economy and attracting foreign investment. The economy is bolstered by annual remittances from abroad representing about 15% of GDP, mostly from Albanians residing in Greece and Italy; this helps offset
the towering trade deficit. The agricultural sector, which accounts for over half of employment but only about one-fifth of GDP, is limited primarily to small family operations and subsistence farming because of lack of modern equipment, unclear property rights, and the prevalence of small, inefficient plots of land. Energy shortages because of a reliance on hydropower, and antiquated and inadequate infrastructure contribute to Albania’s poor business environment and lack of success in attracting new foreign investment needed to expand the country’s export base. The completion of a new thermal power plant near Vlore has helped diversify generation capacity, and plans to upgrade transmission lines between Albania and Montenegro and Kosovo would help relieve the energy shortages. Also, with help from EU funds, the government is taking steps to improve the poor national road and rail network, a long-standing barrier to sustained economic growth.

- GDP (purchasing power parity – 22.9B (2009)
- GDP (per capita) $6300 (2009 estimate)
- Labor force by occupation:
  - agriculture: 58%
  - industry: 15%
  - services: 27% (2006 est.)
- Unemployment rate – 12.8% (but may be closer to 30% due to subsistence farming)
- Population below poverty line – 25%

**Health and Illness**

Life expectancy is 78.13 years (male 75.45, female 81.07) ranking Albania 116th in the world.
Infant mortality is 20.21 per 1,000 live births ranking the country 51st out of 224 countries.
The rate of smoking is notably high in Albania; At least 64% of men are smokers while only 19% of females smoke [9].

**Major Causes of Death** [2,3]

The UN reports a Crude Death Rate for Albania at 5.4/1000 inhabitants. For the current population estimate this would yield total mortality at just under 20,000 deaths. Total annual mortality in Albania has been reported by various sources at 18,000 – 22,000 deaths of which approximately 60% will need palliative care. Mortality data may be underreported. Ministry of Health data for 2004 indicated 17,748 total deaths. The major causes of death are noted below:

- Circulatory Disease    50.1%
- Cancer                16.4%
Cancer is a growing cause of death in Albania. In 2004 16.4% of total mortality was from cancer. For females in 2004 13.7% of total mortality was from cancer. For women top cancers included gastrointestinal, breast, and lung each at 13%. For males top cancers in 2007 were lung/bronchus 25.3%, gastrointestinal 12.7%, and prostate 7.3%.

HIV/AIDS

Albania is a very low prevalence HIV/AIDS country. In Albania, 251 cases were reported at the end of 2007, which means there were 40 new cases of HIV infection during the last year. Data shows that HIV could be spread among at risk groups such as injection drug users, men who have sex with men, the Roma community, and commercial sex workers. Currently, there are eight voluntary counseling and testing centers throughout the country. The National AIDS Program within the Institute of Public Health is responsible for coordinating and implementing all HIV/AIDS related activities within the country, guided by the *Strategy for Prevention and Control of HIV/AIDS in Albania (2004-2010)*. By 2006, a Country Coordination Mechanism (CCM), chaired by the Vice Minister of Health was established within the country. Representatives from all ministries are full members of the CCM as well as civil society organizations and the United Nations.

Since 2004, the Ministry of Health has provided free anti-retroviral treatment for people living with HIV. A new law has been drafted “On Prevention and Control of HIV/AIDS” in Albania and is expected to be approved by the Council of Ministers and the Parliament of Albania.

The Healthcare System

The Albanian health care system has been under resourced and is, like many Eastern European countries undergoing health care reform and health system strengthening. A national health insurance program is also being introduced. The health system in Albania is mainly public. The State is the major provider of health services, health promotion, prevention, diagnosis and treatments for the population of Albania. The
private sector is still developing and covers most of the pharmaceutical and dental services as well as some clinics for specialized diagnosis, mainly in Tirana. The Ministry of Health takes the leading role in the public sector; it is the developer of policy and health strategies, for its regulation as well as the coordination of all participants both inside and outside the system.

The diagnostic and curative health service is organized in three levels: primary health care, secondary hospital service and tertiary hospital service. Public health services and promotion are provided within the framework of the primary health care, supported and supervised from the Institute of Public Health. Other national institutions that offer services are: the National Centre of Blood Transfusion, Centre for the Development and Well-growth of Children, Dental University Clinic, National Center of Quality, Safety and Accreditation of Health Institutions and the Centre for the Continuous Education, the National Centre of Biomedical Engineering and the National Center of Drug Control.

Hospitals

Health care in the hospital service in the Republic of Albania is covered by 41 public hospitals: 22 district hospitals, 11 Regional hospitals, 4 University Hospitals, 1 Traumatology University Centre, 2 psychiatric hospitals, 1 National Centre on Child Development and Rehabilitation.

Primary Health Care

In December of 2006, the Ministry of Health introduced a program of Reform in Primary Health Care. The aim of the reform is Improvement of Primary Health Care as a single source setting. This program implements the Decision of Council of Ministers No. 857, dated Dec 20, 2006 “For Financing Primary Health Care Services” and includes:

• pooling of funds for Primary Health Care, through a Health Insurance Institute (HII),
• introduction of performance based payment,
• increasing autonomy for Health Centers, in management of their own resources
• standardizing services provided according to the package of services approved by the MoH,
• allowing public and private sector for financing services provided
• regionalization of the health care system service planning
Implementation of these reforms started in January 2007. Since then, HII has contracted with almost 420 Health Centers all over the country and with 1625 General/Family Practitioners and 6636 nurses who provide general health care services.

Other Health Assets [3]

There are effectively no nursing homes in Albania and there is a strong culture that families will take care of the sick in their own homes. There are effectively no routine home care services in the country other than emergency mobile services that provide urgent assessment and if necessary transport to the hospital if indicated. To establish palliative care will require the expansion of mobile home care teams that will serve patients in residential settings with back up from hospice units in key hospitals (see plans for palliative care implementation).
Non-Governmental Organizations

Non-governmental organizations are relatively new in Albania and their place in the society is not well understood. There are a number of non-governmental organizations (NGO’s) concerned with palliative care including:

National Association for Palliative Care (NAPC)

The NAPC is the official national organization for the four existing palliative care providers in Albania and promotes training and development of palliative care in the country. Ms. Irena Laska, is Secretary of NAPC, based in Korce, and Dr. Kristo Huta is President. The Association represents palliative care in Albania and is working on national standards as well as the Palliative Care Working Group, chaired by Dr. Huta.

Sue Ryder Care Hospice

Dr. Fatmir Prifti  
Executive Director  
Sue Ryder Care  
Shoqata Ryder Albania  
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ryderalb@icc-al.org

Dr. Prifti leads the Sue Ryder hospice in Tirana. They were the first palliative care provider in Albania, initiated in 1993, and in 2003 opened a 10 bed inpatient unit in Tirana in addition to providing home care approximately 40 patients per day in Tirana and 30 per day in Durres. The Durres program was initiated in 1996. In January of this year the inpatient unit was forced to close due to reduced charitable support. Their support comes mainly from Sue Ryder in the UK as well as support from Irish Aid and Czech Aid. Their income dropped from approximately $300,000 to $130,000 this year due to the international financial crisis. They have gone from a staff of 40 team members to 20 now. They have 3 physicians, 5 RN’s, 1 social worker, one volunteer psychologist, and a secretary and driver in Tirana. There are 2 MD’s, 3 RN’s, 1 social worker, and 1 secretary in Durres. Volunteers are rare in Albania, mostly students and some who help with fundraising. There were more volunteers when the inpatient unit was open.

All services provided by Sue Ryder are free of charge. About 85% of their patients have cancer the rest are elderly with chronic conditions. Also about 80% of their patients do not know their diagnosis or prognosis. About 68% know absolutely nothing, 20-30% may know their diagnosis but not their prognosis, and only about 5% are aware of both.
These are usually patients who have gone outside the country for diagnosis and or treatment and are likely more educated.

Sue Ryder has also been conducting trainings and with help from OSI has developed a palliative care training program that has trained more than 750 professionals in Albania including physicians, nurses, social workers, and psychologists. They have funds to initiate a study of public attitudes related to death and dying in Albania.

All the five Sue Ryder physicians are authorized to prescribe opioids however the forms they have are limited. They do have long acting morphine tablets but only the 10 mg strength is available. They do not have immediate release tablets. They do have injectable morphine. They can get fentanyl patches but they are too expensive to buy. There is no access to methadone and there has been a limit on daily MS dosing of 100 mg.

They have been doing advocacy for palliative care in Albania for a number of years and have formed a working group to develop plans for palliative care that is chaired by Professor Igor Thomaz. They have contacts with the parliament but less influence with the government.

**Caritas Albania**
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Caritas Albania is a Catholic charity that operates 54 health centers throughout the country. They have a palliative care program that operates in 3 of the country’s districts (North Basan, Skoda, and Lezhe). They served a total of 140 patients in the 3 districts last year. Caritas would like to expand the palliative care program to an additional 3 districts. The palliative program has 6 staff all paid part time including one physician, 2 nurses, 1 social assistant, 1 driver, and 1 regional coordinator. They use many church based volunteers to assist.

Financial support for Caritas Albania comes primarily from Caritas Spain. The overall agency has about 300 staff and about 700 volunteers in 6 dioceses with 60+ parishes. They work mostly with those in poverty and in addition to health care provide financial support in the form of good packages.
Mary Potter Palliative Care Association

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Korce, ALBANIA
irenalaska@yahoo.com

Ms. Irena Laska is Director of the Mary Potter Association based in Korce The Little Company of Mary based in the UK supports the Mary Potter program, as does Dorcas Aid International in the Netherlands. Irena described efforts to conduct palliative care education in Albania. For the past three years they have been providing courses in palliative care for physicians and nurses in Korce. They have a home care team providing home based care and have a center that provides day care and respite for cancer patients. The center also provides training and education and does some chemotherapy treatments for the patients. Irena identified several immediate problems that need to be addressed to move palliative care in Albania:

1. Removing the current limits on prescriptive authority so more physicians trained to use morphine can do so.
2. Providing coverage for all palliative care medications not just morphine and anti-emetics. There is also a problem with obtaining chemotherapy medications on a timely basis.
3. Expanding palliative care so that there are teams in all Albanian cities that can outreach to nearby areas.
4. Bringing together a stakeholders group nationally to work on development of the national plan for palliative care in Albania.
5. Currently there is no one with expertise in pediatric palliative care in Albania. A team needs to be identified and trained, probably in another European country such as Romania or Poland that can then provide training to others in Albania.

Open Society Foundation Albania (OSFA)

Mr. Andi Dobrushi is the Executive Director of OSFA since January 2009. The previous director, who had been in the post over 12 years, left and is now working in the United States. The OSFA has been focused on legal and civil society issues in recent years and has not been active in health issues. Andi indicated that he planned to revamp the foundation’s programs and he expressed interest in working on more concrete outcomes related to improving conditions for underserved or disenfranchised populations including the disabled, the mentally ill, and the terminally ill. He indicated that palliative care would be included in the OSFA’s future priorities.

Mr. Andi Dobrushi has decided to include palliative care in the OSFA’s Public Health Program for 2010. We met to discuss his plans for palliative care development and he has discussed these plans with Mary Callaway from the OSI New York office. These plans
will hopefully be finalized soon. The OSFA’s objective for palliative care development are expected to include:

- Funding for an analysis of the legal requirements for palliative care in the country including an audit of all existing laws and regulations that might impede access to opioids and language authorizing palliative care’s inclusion in the health care system.
- To support conduct of a study on the legal and regulatory structures that could impact palliative care's inclusion in the health care system to include both financial and qualitative impact.
- Support for the Ministry of Health approved Palliative Care Working Groups operations.
- To assist in the development of curricula and training centers to teach palliative care to health professionals. Sue Ryder Hospice has proposed to the Faculty of Medicine a one-year ‘diploma' course that would expand their current 9-day training into a recognized course especially for family physicians. Also need a nurse palliative training program in parallel, and something for psychosocial professionals, though both social work and psychology are very new disciplines here.

**The Public Health Situation Related to Palliative Care**

There are numerous problems that have prevented the development of widely available palliative care in Albania. The main problem is the lack of resources for health care generally. There is a longstanding cultural taboo against telling patients their diagnosis or prognosis and up until 1990 it was against the law to inform cancer patients of their condition. While morphine is available in limited forms it has been reported that there are very few physicians in the country who are authorized to prescribe opioids. There is widespread opiophobia and a general belief that morphine kills patients.

**Policy Development**

There remains a need to address and formulate policy for palliative care to develop in Albania. As discussed most current efforts are directed at planning for the inclusion of palliative care in the National Cancer Control Plan. However there is a need for palliative care to be developed for the whole country and for all diagnoses. The PCWG is concerned about this need and is starting with Standards to ensure that the broader needs are understood from the outset. The Parliamentary Commission for Health has also agreed to introduce legislative language in support of palliative care with guidance from the Palliative Care Working Group and with the results of legal analysis.
National Cancer Control Plan

In cooperation with the IAEA and WHO a national cancer control plan (NCCP) was developed in 2006 that prominently includes palliative care as one of three major pillars (see appendix). The NCCP was in limbo until recently when leadership changed at the Ministry of Health.

A National Cancer Control Board has been re-formed under the Ministry of Health to lead efforts at expanding oncology services throughout the Republic (see official decree establishing the group in separate PDF document).

The Deputy Minister of Health Dr. Bardh Spahia chairs the group, which includes:
- Dr. Agim Sallaku, Head of Oncology
- Dr. Alban Ylli, head of Public Health Institute
- Dr. Shahin Kadare, Head of Pathology
- Dr. Kristo Huta, Head of Albanian Association for Palliative Care
- Dr. Niko Civici, Institute of Radiology
- Dr. Nurie Caushi
- Dr. Stephen Connor, Soros Consultant
- Dr. Pal Xhumari
- Dr. Anyla Bulo, Vice Dean of the State Medical School
- Mr. Vasil Miho, World Health Organization

The group meets to receive reports from the leads of the four main areas: 1) Prevention 2) Screening/early detection 3) Treatment & 4) Palliative Care. Dr. Kristo, who is lead for palliative care and I reported on palliative care development. The Palliative Care Working Group is officially a sub-committee of this Board. There is some urgency to
completing and approving the basic plan in 2010 to ensure that work begins before any change in Ministry personnel should occur. The current Deputy Minister and the Minister are both very supportive of improving services for cancer patients throughout the Republic.

**Palliative Care Working Group (PCWG)**

The PCWG was formed to guide the development of palliative care in Albania. The five *objectives of the PCWG* include:

1. Development of **National Palliative Care Standards** that will guide existing and new palliative care programs and will also assist the government in developing licensing and certification requirements.
2. A Country **Needs Assessment** (this document) that will identify the scope of need for palliative care in the country, barriers to palliative care development, and will make recommendations for advancing palliative care in the country.
3. The development of a unified **curriculum and training materials** for continuing education and eventual diploma or fellowship program development.
4. A strategic **plan for Implementation** of palliative care in the country that will be included in the NCCP,
5. A program of public education/engagement as part of the NCCP to include the importance of palliative care and pain control.

The PCWG continues to meet regularly and includes the following individuals:

- Dr. Donjeta Bali Pediatrician, Mother Teresa University Hospital
- Dr. Stephen Connor Open Society Institute, New York
- Dr. Kristo Huta National Association for Palliative Care, Albania
- Ms. Irena Laska Mary Potter Palliative Care Service
- Mr. Vasil Miho World Health Organization, Albania
- Mr. Albert Nikolla Director, Caritas Albania
- Dr. Fatmir Prifti Sue Ryder Albania
- Ms. Rudina Rama Sue Ryder Albania
- Dr. Agim Sallaku, Chief of Oncology, Mother Teresa Hospital
- Ms. Blerta Skendaj Open Society Assistance Foundation, Albania
- Mr. Henrik Zotaj Palliative Home Care Program (SOB)

**Parliamentary Commission for Health**

Dr. Tritan Shehu
t.shehu@unizkm.edu.al
Head, Parliamentary Commission for Health

The Albanian Parliament Commission for Health is responsible for the introduction of all legislation related to health care in the country. The Chair of the Commission, Dr. Tritan Shehu, a former Minister of Health for the country has expressed support for palliative
care and arranged a Parliamentary Hearing on palliative care on July 1st, 2010. I was asked to testify at this hearing along with Dr. Kristo Huta. We stressed three important areas where legislative support was needed for palliative care development in the country:

1. Inclusion of palliative care as a necessary part of the health care system in Albania and the addition of palliative care as a listed area of specialization in health care.
2. A change to the law that will allow additional physicians to be allowed to prescribe opioids.
3. Support for palliative care to be added to the curriculum for teaching health professionals.

The Commission expressed support for action on these items and we pledged assistance in drafting language for these changes.

In addition Dr. Shehu led an Albanian delegation recently the Mediterranean Task Force on Cancer Control meeting in Istanbul. It was agreed that the next conference of this group will be held in Tirana April 29/30th 2011. Dr. Shehu will include palliative care as one of the main themes in the meeting.

**Opioid Availability**

Opioid availability is a significant problem in Albania. Morphine is only available in 10mg injection form and in 10mg long acting tablets. Occasionally 60mg long acting MS is available but only for short periods of time. Fentanyl is available but too expensive to afford. Methadone is only available for injecting drug users as part of the HIV prevention program. A critical problem is that there are only 11 physicians who are trained and allowed to prescribe opioids in the country. Five of these are at the Sue Ryder hospice. Of the 2.5 kg quota for opioids for the country most is used for anesthetic purposes. Sue Ryder Albania uses 280 g of opioids in Tirana per year, mainly injectable.

There is no availability of Oramorph liquid morphine. The physicians working in palliative care in Albania can prescribe Morphine without dosage limitations, while general practitioners can prescribe morphine only with the recommendation of the oncologist and in limited dosage of no more than 100mg per day. The four palliative care programs had to work very hard to obtain special permission from the Ministry of Health to be allowed to prescribe opioids. The Ministry will give a special license to prescribe opioids but they have been resistant to expand this authority. Outside of the approved palliative care providers, each district in the country has only one physician designated to prescribe opioids for all other patients.
Education

Education in palliative care and use of opioids is a critical problem. The Sue Ryder Hospice and the Mary Potter Team in Korce have been conducting training in palliative care. Sue Ryder, through a training program funded by Soros in 2000 has trained over 750 interdisciplinary team members, mainly in the central and northern part of the country. Mary Potter has been doing training for 3 years in the south and east of the country.

Palliative Care is not yet included in the medical or nursing curricula. The Ryder Albania program has introduced a 6-hour course on palliative care in the Faculties of Medicine and Social Work.

During 2007 – 2008 Ryder Care Albania and Mary Potter have trained palliative care physicians and nurses from the North region of Albania in the towns of Shkoder and Lezhe, Elbasan. In the Middle region of Albania, courses have been supported by Caritas Albania.

During 2007 – 2009, the Mary Potter team in Korce has trained all the doctors and nurses of the region in palliative care, pain and symptom control, organizing basic, post-basic and advanced level training.

The Mary Potter team has also organized residential courses with nurses from Korca and other regions of Albania financed by SOROS and LCM (Little Company of Mary).

Palliative Care is now part of the curricula of Medicine, Nursing and Social Sciences faculties, although in the Medicine Faculty Palliative Care as a subject has a limited number of participants, as it is an elective.

There is a need to create a unified national curriculum/course for teaching basic palliative care. Each of the providers has developed their own teaching materials. They have agreed to work collaboratively to create and receive accreditation for such a training course.

National Oncology Center

The National Oncology Center at Mother Teresa University Hospital is the specialty center for Albania for cancer treatment. Patients come from all over the country for treatments and many times family from outlying areas have to take temporary residence in Tirana. The head oncologist, Dr. Agim Sallaku is a strong proponent of palliative care. He has sought permission for the oncology center to be a separate oncology institute with its own funding.
World Health Organization and Global Fund

We met with Guyane Ghukasyan, MPH, Country Program Coordinator, WHO Country Office for Albania. Ms. Ghukasyan informed us that a proposal was submitted to the Global Fund for a Health System Strengthening grant to be administered by the Ministry of Health for national health workforce development that included a program to help develop palliative care in the country. The overall grant is for more than 1 million Euros and the palliative care portion is 91,295 Euros. This project will not just be for HIV but for all patients. The grant will support key recommendations from this needs assessment.

The program will be administered by the Project Implementation Unit (PIU) at Ministry of Health with input from Global Fund and the Country Coordinating Mechanism group. There will be an opportunity to bid on managing the project and it is suggested that a coalition of the organizations currently working on palliative care in Albania submit the bid. The scope of work includes 1) a needs assessment (already drafted), 2) development of guidelines for pain control, 3) funding of a pilot project to explore models of palliative care delivery at 4 sites, 5) exploration of possible funding mechanisms for integration of palliative care into the national health system, 6) development of curricula and training programs for palliative care providers, 7) development of standards and protocols, and 8) establishing a network of palliative care teams.
The Need for Palliative Care in Albania

Current Hospice/Palliative Care Services

In 2007 the following programs provided palliative care to the cancer patient population in need:

- Caritas Albania 5%
- Mary Potter Team 5.3%
- Service Palliative Care Albania (SOB) 8.6%
- Sue Ryder 14.8%
- No palliative Care 66.3%

Mortality

The UN reports a Crude Death Rate for Albania at 5.4/1000 inhabitants. For the current population estimate this would yield total mortality at just under 20,000 deaths. Total annual mortality in Albania has been reported by various sources at 18,000 – 22,000 deaths of which approximately 60% will need palliative care. Mortality data may be underreported. Ministry of Health data for 2004 indicated 17,748 total deaths. The major causes of death are noted below:

If we look at the mortality by diagnosis data for 2004 [3]:

<table>
<thead>
<tr>
<th>Disease</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MoH Data</td>
</tr>
<tr>
<td></td>
<td>%</td>
</tr>
<tr>
<td>Cancer</td>
<td>16.4%</td>
</tr>
<tr>
<td>Circulatory</td>
<td>50.1%</td>
</tr>
<tr>
<td>Respiratory</td>
<td>5.3%</td>
</tr>
<tr>
<td>Injuries</td>
<td>6.8%</td>
</tr>
<tr>
<td>Non Specific</td>
<td>11.8%</td>
</tr>
<tr>
<td>Other</td>
<td>9.6%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
</tr>
</tbody>
</table>

A considerable number are in non-specific or other categories making them hard to classify. Total mortality from these major causes of death is about 18,000 in 2004. It is likely that this number has grown in 2010 to at least 19,000. In addition to this palliative care also provides services to patient’s families. The chronically ill non-cancer population is estimated by including circulatory, respiratory, and non-specific deaths.

We can use 2 different existing methods to estimate the need for palliative care in
Albania. Using the population-based approach recommended by Gomez & Stjernsward\(^1\) if we calculate 60% of total mortality as the need for palliative care we would project a total of 11,400 (19,000 * 0.6) patients annually needing palliative care.

Using Higginson’s method\(^2\), 100% of cancer and 66% of other chronic illnesses we would project a total of 10,772 patients (2907 cancer and 7865 \(11,916 \times 0.66\)) chronic non-cancer).

Given that additional patients will need palliative care prior to their year of death, if we propose that approximately 12,000 patients per year will need palliative care and we assume an average of 2 months of service we project a daily census of about 1975 patients on service at any given time for the full need to be met. In addition there are usually 2 or more family members directly involved in care for each patient. Thus care would be given to at least 36,000 persons annually. For just the cancer population there could be a total average daily census of approximately 475 patients.

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\(^1\) Gomez X.G., Stjernsward J. WHO Public Program for Palliative Care, cap V, 2005.

**Health Workforce Needs**

The current population of Albania is between 3.1 and 3.6M people. Using a population approach we can also project the need for palliative home care services and hospice and palliative care inpatient beds/units. To provide home based and inpatient care to a population of 1,975 patients per day will require some reallocation of health professional resources for both the urban and rural areas.

Two methods are used to use to calculate the staffing needs for home-based care and inpatient care. One is based on the projected average daily census and the second is an epidemiological population based approach proposed by Gomez

Using the average daily census, for home-based care we will use a ratio of one full time equivalent (FTE) nurse for every 5 patients on daily service and for physicians we will use one FTE for every 25 patients on service. In addition other staff are needed for the clinical services including social workers, home care aids, therapists, and drivers. It is estimated that one FTE of other clinical is needed for every 10 patients on service.

Using these data we can project that 395 nurses will be required, 79 physicians, and 198 other clinical support staff.

Using the population based approach the following ratios are used:

For home-based care:
- 3 physicians per 100,000 population
- 12 nurses per 100,000 population
- 6 other clinical staff per 100,000 population

For inpatient care:
- 1.5 MD’s for every 10 inpatients
- 15.5 nurses for every 10 inpatients
- 4 other clinical staff for every 10 inpatients

Using these ratios would project a need for a population of 3,100,000 the following staffing:

For home-based care:
- 93 physicians
- 372 nurses
- 186 other clinical staff

For inpatient care (for 130 beds – see below)
- 15 physicians
- 155 nurses
- 40 other clinical staff
Comparison of Projected Need by Method

<table>
<thead>
<tr>
<th>Total Staffing using the population based method</th>
<th>Total Staff using the ADC method</th>
</tr>
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<tbody>
<tr>
<td>• 108 physicians</td>
<td>• 79 physicians</td>
</tr>
<tr>
<td>• 527 nurses</td>
<td>• 395 nurses</td>
</tr>
<tr>
<td>• 226 other clinical staff</td>
<td>• 198 other clinical staff</td>
</tr>
<tr>
<td>• 861 total clinical staff</td>
<td>• 672 total clinical staff</td>
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</tbody>
</table>

We see that the population method calls for significantly more staff. The difference will be due to population differences with Albania having a much younger population and how much emphasis or need there will be for inpatient beds and inpatient staff. The ADC method may be more appropriate for Albania. Cancer patients will require about 25% of these resources.

This projection does not include administrative staff. If we use an estimate of 25% additional administrative staff we would add another 168-215 or a total of 840-1076 staff. Palliative care teams generally work well with caseloads of up to 50 patients. Additional teams can be formed under one administrative authority for a given geographic area, as scale up continues. To care for a daily census of 1,975 patients would eventually require approximately 40 such teams to serve the country.

**Bed Need**

To estimate the need for inpatient palliative or hospice care beds we can again use the average daily census and apply a percentage to the number of patients needing inpatient care on a given day. In the United States the percentage is 3% of hospice days, however this does not account for other non-hospice palliative care patients so an estimate of 5% will be used. If we apply this percentage to the average daily census of 1,975 we have a need for about 100 beds. Another method used in Catalonia to estimate bed need is 5 beds per 100,000 population. Using this method also results in a projection of 155 beds. Given the fact that the vast majority of patients die at personal residences (94%) and the desire to continue that trend, care should be taken not to over emphasize inpatient palliative care. For planning purposes, need for occupancy turn over and growth in the population it would be safe to estimate bed need at of 100 beds for the country.

**Plans for Scaling up Palliative Care in Albania**

The present estimate is that only 33.7% of cancer patients are receiving palliative care from the 4 existing providers means that two-thirds of cancer patients do not receive palliative care and none of the non-cancer patients are receiving palliative care. If we use the estimate of 2,907 cancer deaths then 980 cancer patients are served annually leaving 1,927 needing service plus 7,865 non-cancer for a total unmet need of 9,792
patients. If adjusted to current need of 12,000 only about 1,000 of the need is being met or 8.3%.

A full strategic plan for palliative care implementation is needed however we can propose some initial targets for growth over an initial 5 year period of 2011-2016. A goal would be in a 5-year timeline to develop services, train personnel, and to realign financing so that perhaps 35% of the total need would be met. The Palliative Care Working Group needs to consider the process for this roll out and the Ministries will need a detailed strategic plan that demonstrates the costs and benefits of increased palliative care delivery. Some general recommendations to begin this process are proposed here.

- It is realistic to begin in the first year with expansion of services in Tirana, Durres, & Korce. The existing palliative care programs need funding as pilot programs.
- It may be necessary to begin by focusing on palliative care for cancer patients. Palliative care for those with other life threatening conditions should also begin to be offered from the beginning to avoid creating the perception that palliative care is only for cancer.
- Almost 20% of the population lives in Tirana. In addition there are many patients that temporarily relocate to the city during treatment.
- There is an opportunity to develop Sue Ryder Albania into a national palliative care training center in partnership the other 3 hospice/palliative care providers.
- Palliative care services are most efficiently delivered where people live. Home based care provided by an interdisciplinary group of professionals, and if possible volunteers, is the preferred model, with the back up of a limited number of inpatient beds strategically placed in connection with existing hospitals.
- Inpatient facilities for palliative care patients should strive to be more residential like in appearance with amenities such as provision for family members to sleep and cook. This can be done in distinct wards or sometimes in separate facilities that utilize hospital central services with some remodeling. For example if you plan inpatient centers of 25-bed size you could place 1 in Tirana and the remaining 3 in other parts of the country.
- After Tirana expansion of palliative care programs could begin in other larger Albanian cities such as Shkoder, Vlore & Sarande in the South. Expansion to rural areas can be built from nearby cities.
- Early on a monitoring and evaluation program should be identified and all palliative care providers should be required to participate. The M & E program should be linked to the approved standards for palliative care and should include structure/process/outcome measures and use of M & E data in reported quality improvement activities.
### Timeline
Immediate timeline of activities

| Albania | 1. Development of Palliative Care Standards for Albania | 1a. Translation of drafted national standards adapted for Albania from Romanian | 1a. Completed  
1b. Sept 2010  
1c. October 2010  
1d. October 2010  
1e. December 2010 |
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<tr>
<td></td>
<td>Including recognition of palliative as an area of specialization or sub-specialization in health care</td>
<td>1b. Review/modify draft standards</td>
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<td></td>
<td></td>
<td>1c. Distribute revised draft standards to working group</td>
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<td></td>
<td></td>
<td>1d. Review drafted standards at working group meeting</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>1e. Present to MOH and identify need for development of licensing regs</td>
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</table>
|         | 2. Development of a comprehensive Country Palliative Care Needs Assessment for Albania | 2a. Complete first draft of country needs assessment | 2a. Sept 1\textsuperscript{st} 2010  
2b. Sept 15\textsuperscript{th} 2010  
2c. October 1\textsuperscript{st} 2010  
2d. Week of Oct 4\textsuperscript{th} 2010  
2e. Oct 10\textsuperscript{th} 2010  
2f. Dec 31\textsuperscript{st} 2010 |
|         |                                                        | 2b. PC working group to send edits to document | |
|         |                                                        | 2c. Complete final draft | |
|         |                                                        | 2d. Get stakeholder comments and finalize | |
|         | 3. Development of accredited curricula and training center | 3. Create a teaching handbook that will standardize teaching of basic palliative care in Albania | 3. Dec 31\textsuperscript{st} 2010 |
|         | 4. Conduct legal review and make recommendations to Parliamentary Commission for Health | 4a. OSIAF Albania consultant attorney to conduct a legal review of Albanian laws impacting palliative care. | 4a. October 2010 |
|         | 5. Complete drafting of National Palliative Care Standards | 5. Dr. Huta to modify draft standards with NAPC & PCWG input | 5. Dec 31\textsuperscript{st} 2010 |
|         | 6. Draft Palliative care section of National Cancer Control Plan. | 6. Palliative care section drafted and submitted | 6. Dec 31\textsuperscript{st} 2010 |
A general timeline with major milestones is proposed as follows:

By the end of:

2010  
Completion of the National Cancer Control Plan to include palliative care  
Establish a standardized & accredited course for basic palliative care training  
Complete national standards for palliative care

2011  
• Establish and fund pilot palliative care programs in Tirana, Durres, and Korce  
• Develop a strategic implementation plan for palliative care in Albania  
• Conduct economic and legal analyses  
• National Standards expanded to regulations for licensure  
• Initial funding for palliative care included in budget for 2012

2012  
40% national coverage for cancer achieved, 5% for non-cancer.  
• Target 1550 patients or 13% of overall need met

2013  
50% national coverage for cancer achieved, 10% for non-cancer  
• Target 1850 patients or 15.4% of overall need met  
• Expansion of inpatient and home based palliative care to 3 other major cities

2014  
60% national coverage for cancer achieved, 20% for non-cancer  
• Target 3300 patients or 27.5% of overall need met  
• Expansion of home based palliative care to other cities

2015  
70% national coverage for cancer achieved, 30% for non-cancer  
• Target 4400 patients or 36.6% of overall need met  
• Expansion of palliative care to rural areas of the country

**Summary**

• Albania has a small but dedicated group of health care activists that are committed to seeing the development of palliative care move forward.
• The Ministry of Health has approved a palliative care working group to prepare recommendations for consideration by the government as part of the development of the National Cancer Control Plan.
• The Parliamentary Health Commission is willing to introduce legislation to recognize palliative care in the health care system and to support Educational program development and improved access to oral opioids.
• Palliative care has been provided in Albania since 1993 but there is no source of funding and no recognition of palliative care as a specialty or sub-specialty.
• The total need for palliative care has been estimated at up to 1,975 patients per day and approximately 12,000 patients per year (including approximately 3,000 cancer patients). In addition at least twice as many family members will need support.
• Up to 40 palliative home care teams are needed for the country. There is an estimated need for 100 inpatient beds for stabilization and treatment of severe symptoms throughout the Republic.
• Essential medications for palliative care are difficult to obtain in the country and there are too few physicians that are authorized to prescribe opioids.
• There are no curricula, courses or training centers within the country for professionals to be trained or certified in palliative care though there has been quite a lot of ad hoc training by 3 of the current palliative care providers. There is also a proposal to create unified palliative care curricula.
• Health care resources are quite limited in Albania, particularly since independence was gained from the Soviet Union. Most patients have to pay something for their care even when it is fully covered.
• National standards for the provision of palliative care in Albania have been initiated and need to be adapted for Albania.
• A system for monitoring and evaluation of palliative care should be developed and implemented from the inception of palliative care delivery.
• Including palliative care in the health care system will help Albania move closer to compliance with European Union standards.

Recommendations

Policy

1. A legal/regulatory framework for inclusion of palliative care in the existing health care system is needed. The Parliamentary Commission for Health has expressed willingness to introduce legislation for this, however a legal analysis is needed to ensure that all obstacles and gaps are identified for inclusion in legislation.
2. The palliative care section of the National Cancer Control Plan needs to be completed and submitted for approval.
3. This comprehensive national needs assessment for palliative care should be expanded into a national strategic plan for palliative care in Albania that builds on the recommendations in the National Cancer Control Plan.
4. The government-sanctioned task force that has been formed to assist in the development of recommendations for palliative care in Albania should expand its scope to include non-cancer palliative care provision.
5. National standards for palliative care operation are needed. The palliative care working group will review recently drafted national associations standards.

Medication Availability

6. Policy on the provision of opioids and other essential palliative care medications needs to be clarified to eliminate inconsistencies in prescribing, dispensing, distribution, and use. Legislation and regulation related to narcotics should be reviewed and appropriate changes made that support improved access to opioids.
7. The number of physicians allowed to prescribe opioids needs to be increased. A standardized training program in pain assessment and treatment for physician prescribers is needed.

8. Essential palliative care medications that are on the WHO list of recommended medications but are not available in Albania need to be made available.

**Education**

9. A palliative care educational program and training center needs to be established using agreed upon and state accredited curricula.

10. Palliative care curricula needs to be introduced into professional school training for physicians, nurses, social workers, and psychologists and for post-graduates.

11. A program for teaching palliative care is needed for continuing medical education that is consistent with (9) above.

12. A program of public education about the importance of palliative care needs to be developed and implemented.

**Implementation**

13. A funding mechanism needs to be established to encourage the expansion of palliative care. Reductions in cost for hospitalization could be used to grow interdisciplinary palliative home care and palliative care should be included in the basic benefits package. An economic impact analysis is needed.

14. Gradual scale up of home care teams and inpatient units should be undertaken to meet the need identified in the strategic plan for palliative care.

Respectfully submitted,

Dr. Stephen R. Connor, PhD
Dr. Kristo Huta, MD
REFERENCES


2. Palliative Care Needs Assessment for Albania, by Stephen Connor, PhD & Hrant Karapetyan, MD


5. WHO Statistical information system (WHOSIS) http://www.who.int/whosis/en/index.html


Appendix A: WHO Definition of Palliative Care

Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care:
  • provides relief from pain and other distressing symptoms;
  • affirms life and regards dying as a normal process;
  • intends neither to hasten or postpone death;
  • integrates the psychological and spiritual aspects of patient care;
  • offers a support system to help patients live as actively as possible until death;
  • offers a support system to help the family cope during the patients illness and in their own bereavement;
  • uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
  • will enhance quality of life, and may also positively influence the course of illness;
  • is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

**WHO Definition of Palliative Care for Children**

Palliative care for children represents a special, albeit closely related field to adult palliative care. WHO's definition of palliative care appropriate for children and their families is as follows; the principles apply to other paediatric chronic disorders (WHO; 1998a):
  • Palliative care for children is the active total care of the child's body, mind and spirit, and also involves giving support to the family.
  • It begins when illness is diagnosed, and continues regardless of whether or not a child receives treatment directed at the disease.
  • Health providers must evaluate and alleviate a child's physical, psychological, and social distress.
  • Effective palliative care requires a broad multidisciplinary approach that includes the family and makes use of available community resources; it can be successfully implemented even if resources are limited.
  • It can be provided in tertiary care facilities, in community health centres and even in children's homes. [1]
Appendix B

Albanian Palliative Care Working Group
Meeting Wednesday June 30, 2010 3 PM

Draft Agenda

1. Update on activities since April meeting
   a. Standards
   b. Legal review
   c. Economic analysis
   d. Study Tour (East-East)
   e. Workshops (standards and WHO conference)
2. Review of preliminary results of needs assessment (handout)
3. Review of palliative care section of the National Cancer Control Program (handout)
4. Status of membership of the PCWG
5. Objectives of the Working Group
   a. Development of Palliative Care Standards for Albania
      i. Including recognition of palliative as an area of specialization or sub-specialization in health care
   b. Development of a comprehensive Country Palliative Care Needs Assessment for Albania
   c. Development of plans for palliative care implementation to include:
      i. Inclusion of palliative care action plans in the National Cancer Control Plan
   d. Development of Curricula and Training Centers
      i. Diploma in palliative care for MD’s, RN’s, & Psychosocial professionals?
      ii. Inclusion in medical, nursing, & professional school curricula
      iii. Need for unified accredited curricula & provision of continuing education requirements
      iv. Creation of a resource center for PC
   e. Public Education/Engagement. Public Focus Groups
6. Pediatric Palliative Care
7. EU/EC Funding possibilities
8. Other / Future Meeting Plans
Appendix C
Appendix D

Scope of work for review of laws, policies, and regulations in Albania with the potential to impact provision of palliative care

OSI is seeking proposals to conduct a review of all health related laws, policies, practices, and regulations in the Albanian Republic that have the potential to impact the inclusion of palliative care in the health care system. Including a set of recommendations for adding or modifying existing legal or regulatory language. The review should include but not be limited to the following general areas:

• Licensure of all health facilities and health care delivery programs
• Licensure of health professionals including scope of practice
• Education of health professionals both initial training and ongoing continuing education
• Laws, policies, and practices concerning the prescribing, use, handling, and administration of opioids and other psychoactive substances used in symptom management
• Legal descriptions of health related services provided in the country
• Language related to approval of recognized specialties in health care
• National policies and plans for reforming health care or setting strategies or priorities for health care including a national cancer control plan
Appendix E

Decree Establishing National Cancer Control Board

Inderuar Z./Znj.

Ministria e Shëndetësisë në kuadër të ristartimit të aktivitetit për përfundimin e plotë të Programit Kombetar të Kontrollit të Kancerit ju fion të jeni pjesë e Komitetit Kombëtar për Kontrollin e Kancerit në Shqipëri, një organizëm autonom dhe nën koordinimin e Ministrisë së Shëndetësisë. Ky Komitet do të ketë për detyrë rivlerësimin e Drafjit të Parë të bërë dy vjet më parë, nën prizmin e ndryshimeve të kësaj periudhe të kaluar si dhe detajimet e mëtejshme me grupe ekspertësh të planeve konkrete të veprimeve për çdo komponent të veçantë, nga prevencioni, zbulimi i hershëm, diagnoza/trañtimi dhe palaciioni.

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Konsulentë të Jashtëm, në mbështetje të “Komitetit Kombëtar për Kontrollin e Kancerit” do të jenë:

Adelina Mazreku
Edmond Çeliku
Arben Beqiri
Gëzim Selenica
Krenar Preza
Donika Materaku
Rustem Paci
Fatmir Priëni

Mbledhja e pare e Komitetit nën drejtimin e Ministririt të Shëndetësisë Z. Petrit Vasilii është menduar të mbahet në datën 29.01.2010, ora 12.00, salla e mbledhjeve në Ministrinë e Shëndetësisë.

Bashkencjitur keni dhe drafitën e parë të programit të KKK.

ZV/MINISTËR

BARDH SPAHIA
Appendix F: EU Accession Document

Instrument for Pre-Accession Assistance (IPA)

Multi-annual Indicative Planning Document (MIPD)

2009-2011

Albania
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Executive Summary
As a potential candidate country, Albania benefits from the first two components of IPA, including Component I for Transition Assistance and Institution Building and Component II for Cross-Border Cooperation. The indicative allocations to Albania under the Multi-annual Indicative Financial Framework (MIF) for 2009-2011 amount to EUR 269.4 million. Assistance will be in line with the recommendations of the 2008 Enlargement Strategy and Progress Report, the European Partnership priorities and will address the requirements under the SAA.

In the area of democracy and rule of law, the capacity of the Albanian institutions remains to a large extent limited, in particular as regards the judiciary, the implementation of public administration reform and the fight against corruption and organised crime. In addition, the implementation of the SAA, which has started after the final ratification on 1 April 2009, will require strong administrative capacities in almost all acquis related areas to meet the requirements identified in the SAA. Structural reforms are not yet fully implemented and more efforts are still needed in the economic area to improve the business environment.

Therefore, EC assistance to Albania in the forthcoming three year period, will address key issues such as public administration reform and rule of law enforcement, in particular as regards good governance and anti-corruption measures. This emphasis is reflected in a further increase of funds allocated to the area of political requirements. Strengthening administrative capacity with a view to the implementation of the SAA is given a high priority, to support the Albanian authorities in fulfilling the requirements of the SAA. There is a need to further support structural reforms in the country and to invest in related infrastructure, in particular in the area of regional development and acquis related infrastructure.

IPA support under the Transition Assistance and Institution Building Component will amount to EUR 269.4 million and should assist Albania in the following main areas:

Political requirements: IPA will support the implementation of the public administration reform, strengthen the capacity of key institutions and therefore contribute to develop good governance. In this context, IPA shall also strengthen European integration structures, contribute to establishing financial control and help to prepare the decentralised management of EU funds. IPA intends to support the judicial and police reform, support anti-corruption measures and strengthen the political system in order to carry out elections and census according to EU standards. IPA will also support the development of the media sector, including the digitalisation of broadcasting, promote the social and economic inclusion of minorities and vulnerable groups and promote civil society dialogue. Funding for these areas will range between 30% and 35% of the total allocation foreseen for component I.

Socio-economic requirements: IPA will assist the Albanian authorities in improving public finances, implementing structural reforms and developing the functioning of the labour market through increased flexibility and better links with the education system. IPA intends to assist improvement in access to essential services and economic markets and protection of cultural heritage. Funding for these areas will range between 20% and 25% of the total allocation foreseen for component I.
**Ability to assume the obligations of membership:** IPA will support Albania's approximation to EU standards in the areas of internal market, sectoral policies and justice, freedom and security. IPA can help to reinforce the structures necessary for implementation of the SAA and *acquis*. Particular attention should be devoted to the areas of agriculture and rural development, regional development, environment, consumer protection, transport and energy. Funding for these areas will range between 40% and 50% of the total allocation foreseen for component I. This could also include major municipal infrastructure projects as a possible medium-term response to the financial crisis by helping to soften the general slowdown of economic growth and to maintain economic stability, growth and jobs. Supporting programmes are foreseen to allow Albania to participate in Community agencies and institutions, as well as in Community programmes. Access should be also provided to the Project Preparation and Technical Assistance Facility. IPA support for **Cross-Border Co-operation** will amount to EUR 31.5 million and will address cross-border activities between Albania and EU Member States as well as with adjacent candidate countries and potential candidates, complementing the above sub-components.

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Appendix G: Ministry of Health: Health Indicators
Republic of Albania
Ministry of Health

AN OVERVIEW OF THE HEALTH CARE SYSTEM IN ALBANIA
SOME PERFORMANCE INDICATORS

TIRANA, ALBANIA, JANUARY - 2009
MINISTRY OF HEALTH OF ALBANIA
Address: Bulevardi "Bajram Curri" Tiranë, Albania
Phone: +355 4 362937
E-mail: info@moh.gov.al
Web Site: www.moh.gov.al

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MINISTRY OF HEALTH

AN OVERVIEW OF THE HEALTH CARE SYSTEM IN ALBANIA

SOME PERFORMANCE INDICATORS

2008

Tirana, Albania, January - 2009
Dear Reader,

The Ministry of Health is undertaking deep reforms for the modernisation of the health system, by increasing the quality of services, professional capacities. Part of these reforms is the reorganisation of the health system, increase of weight and role of health insurance system widening public network, prior support for the regional hospitals, as well the creation of the necessary spaces for the motivation of the private initiatives in this sector.

Our goal is the creation of an effective, well managed system, capable to offer health care for all Albanian citizens.

We are working with our institutions and international partners for the harmonization of projects and priorities to fulfill in time and quality the engagements that derive from the National Strategy of Health.

Our goal is the undertaking of all the necessary reforms and measures that guarantee the fulfilment of our constitutional duty for health care for citizens, as well approach our health system to that of the member nations of the European Union.

This overview gives a clear picture and development of our health care system in Albania.

I am convinced that by acknowledging these facts will help us to achieve our objectives. Throughout this publication we intend to draw your attention of our healthcare system.

Anila GJOKO
MINISTER
Albania in Figures
Basic Geographical and Socio-Political Information.

Albania is situated in the south west of the Balkan Peninsula and covers an area of 28,748 km², 34.8% of which is made up of forests, 15% pastures, 24.3% agricultural soil, 4% lakes. The landscape is mainly mountainous with an average height of 714 m above sea level, almost twice as high as the average for Europe. The boundary of Albania is 1,094 km long, of which 529 km with Former-Yugoslavia (north and north east) and 271 km with Greece (south and south east). Albania’s coastline is 476 km long.

The (current) total population of Albania is 3,152,600 inhabitants. The average age of the population is 28.6 years old, an average higher than other European countries. One third (33%) of the population is under 15 years old, approximately 40% under 16 years old and nearly half under 25 years old.
Palliative Care Needs Assessment for Albania

BIRTH RATE (life births per 1000 population)

LIVE BIRTH, DEATHS AND NATURAL INCREASE (per 1000 inhabitants)

PROBABILITY OF DYING (per 1000 inhabitants)
HEALTH CARE SYSTEM

The health system in Albania is mainly public. The State is the major provider of health services, health promotion, prevention, diagnosis and treatments for the population of Albania. The private sector is still developing and covers most of the pharmaceutical and dental services as well as some clinics for specialized diagnosis, mainly being situated in Tirana.

Ministry of Health takes the leading role in the public sector; it is the developer of policy and health strategies, for its regulation as well as the coordination of all participants both inside and outside the system.

The diagnostic and curative health service is organized in three levels: primary health care, secondary hospital service and tertiary hospital service.

Public health services and promotion are provided within the framework of the primary health care, supported and supervised from the Institute of Public Health.

Other national institutions that offer their services are: the National Centre of Blood Transfusion, Centre for the Development and Well-growth of Children, Dental University Clinic, National Centre of Quality, Safety and Accreditation of Health Institutions and the Centre for the Continuous Education, the National Centre of Biomedical Engineering and the National Centre of Drug’s Control.
PRIMARY HEALTH CARE

The main mission of the Primary Health Care is to preserve the continuing improvement of health and to assure a living with the best health conditions for the people in accordance with the objectives “health for all”. It represents the basic level of service where the person directly meets the health service for the first time and offers basic health care, near the people, where they live. Many elements of the public health practice are integrated primary health care services and gives priority to the hygiene-epidemiological situation, population’s health demand, and the most emergent and cost effective programs in the fields of primary health care.

On December 2006, MoH introduced the Reform in Primary Health Care. The aim of the reform is the improvement of Primary Health Care in a single-source setting. It implements the Decision of Council of Ministers No. 657, date 20.12.2006 “For financing Primary Health Care Services” and it consists on:
- pooling of funds for Primary Health Care, near Health Insurance Institute,
- performance based payment,
- autonomy giving to Health Centers, it will be given a certain level of autonomy for objectives setting and in the management of their own resources according to services provided,
- services provided according to the package of services approved by MoH,
- setting in the same star/possibility of public and private sector for financing services provided by them, through the extension of services that are financed through the insurance scheme of Primary Health Care,
- regionalization of health care system, service planning in regional level to better meet population needs.

Implementation of the Reform started on January 2007. After January 2007, HI/RDHI has contracted with almost 420 Health Centres all over the country or with 1625 General/Family Practitioners and 6636 nurses who provide general services of health care.

COUNTRY EPIDEMIOLOGICAL PROFILE

Albania seems not to have experienced a fall in life expectancy after dramatic political and economic changes. Despite the fact, that life expectancy at birth is lower than most of developed European countries, it is somewhat
higher that most of the countries of Eastern and Central Europe. Healthy life expectancy is lower compared to EU countries, including the new members after 2004.

Infant mortality remains high by EU standards, but is decreasing steadily. The same is true for child (under 5) mortality rate, while maternal mortality remains a concern and doesn’t show clear trends of decreasing. Infant mortality shows significant differences among districts. It ranges from under 5/1000 to more than 35/1000.

The epidemiological profile is changing: Levels of cardiovascular diseases, cancer and external causes of death are increasing. The burden of communicable diseases is decreasing in general terms, but some infections as HIV/AIDS are increasing. These diseases cause 0.5% of all deaths. There are 18 new cases of tuberculosis per 100 000. EU25: 13, EU15: 11, EU10: 26.
There are 0.7 new cases of HIV infection per 100,000. The rates of sexually transmitted infections (per 100,000 per year) are low compared to EU figures: 0.2 new cases of syphilis EU25: 3, EU10: 5 and 0.6 new cases of gonococcus infection EU25: 9, EU10: 6.

Brucellosis remains stable during the last two years after more than ten years of an apparent epidemic increase. Most of the vaccine preventable diseases are under control with several of them in the way of eradication. During the last year, anyway, were reported some cases of measles after four years of 0 cases. Viral Hepatitis is still a problem for the country.

Gastroenteritis in children is decreasing with rates getting close to those of EU; The rate of children under 5 dying from diarrhea is 0.4 per 100,000. EU25: 0.4.

Cardiovascular diseases are the leading causes of death; 52% of the total number of deaths. Within this group, the major killers are – ischemic heart disease: cause of 7% of the disease burden and 15% of all deaths: 128 deaths per 100,000. the indicator is lower than those reported by central and eastern European countries but higher than western European countries (EU25: 104, EU15: 94, EU10: 168).

Cancer is responsible for 14% of all deaths: 132 deaths per 100,000 populations. Cancer incidence remains lower than EU (There are 96 new cases of cancer per 100,000 per year, a quarter of the rate in the EU25), but is increasing. For some cancers as Breast Cancer the increase can’t be explained by demographic changes only. U25 50.
There are 4.2 new cases of cervical cancer per 100,000 per year: a rate slightly higher than that in the EU25. EU25: 3.2. There are 20 new cases of breast cancer and 13 new cases of lung cancer per 100,000 per year.

Mental health is another dimension of health affected by changes in Albanian population. Suicide rates, despite being lower than those reported by EU countries are steadily increasing. Neuropsychiatry disorders account for 20% of the total disease burden and 3% of all deaths. EU25: 4%.

There are 4 suicides or self-inflicted injuries per 100,000. EU25: 12, EU15: 10, EU10: 18.

Unintentional injuries are responsible for 43 deaths per 100,000 per year, a figure much higher than rates of western European countries. EU25: 45, EU15: 39, EU10: 13.

Injuries from road traffic accidents cause 12 deaths per 100,000.

Respiratory diseases cause 6% of all deaths: 47 deaths per 100,000 populations. EU25: 47, EU15: 48, EU10: 40.

Smoking accounts for 22% of the disease burden. Alcohol consumption causes 6% of the disease burden. Obesity causes an estimated 10% of the disease burden, and physical inactivity, 5.3%.
HOSPITAL SERVICE

Health care in the hospital service in the Republic of Albania is covered by 41 public hospitals: 22 district hospitals, 11 Regional hospitals, 4 University Hospital, 1 Traumatology University Centre, 2 psychiatric hospitals, 1 National Centre on Child development and rehabilitation.

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<td>Hospitals (per 100 000)</td>
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<td>Hospital beds (per 100 000)</td>
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<td>Average length of stay (days)</td>
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<td>Bed occupancy (in days)</td>
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With the consistent interventions carried out from the state budget and that of donors, the hospital infrastructure is improved and also the medical devices and equipment are improved as well. The design and implementation of some standardized protocols of treatment would assure efficient usage of the financial resources and would ensure the quality of service delivered.

MOH is in the process of passing the law on “Financing of hospital health care offered in public hospitals from the obligatory scheme of insurance of health care”.

MOH, considering them as a priority, finances from the budget of state, the Psychiatric service, the national service of blood transfusion, the electro-
medical repair service, the helicopter transporting unit. The national service of blood transfusion is being reconfigured aiming in its centralisation as follows: 1 National Centre of Blood Transfusion, 4 Regional centres of blood banks, 15 collection and delivery blood banks, 11 blood banks for the hospital services.

PHARMACEUTICAL SERVICE

The pharmaceutical service in Albania is mainly private. Essential parts of this service, throughout it works are: 3 local private manufacturers, 216 pharmaceutical warehouse, 1020 pharmacies, 210 pharmaceutical private agencies, 42 hospital pharmacies (which are the only ones that offer public service). This service aims to a rational usage of a number of effective drugs, safe and with high quality and to the availability and reasonable prices for all the population. Although this service is private, it is monitored rigorously from the Ministry of Health and National Center of Drugs Control. Compared to the past, Albania has now a high number of registered drugs. This number is being increasing in continuation. Up to now, are registered 3400 drug form-doses.

Within the Ministry of Health exercise their activity two important Commissions, settled on by the Decision of the Council of Ministers, after being proposed by the Minister of Health, once a year:

- the Drug Commission on Drafting and Reviewing the Reimbursement List, which once a year selects the drugs that are going to be reimbursed by the Health Insurance Institution (HII),
- The Drug Pricing Commission which, once a year approve the maximal CIF(cost, insurance, freight) prices of imported drugs and for local manufactured drugs.

As mentioned above, in Albania exists the Reimbursement System, part of which is the Reimbursement List. The number of reimbursement drugs is 450.

In order to approximate the Albanian Pharmaceutical Legislation with the European Directives, there is a collaboration with the European Drug Agen-
cies, of the participates states in European Union. Also we are over-reviewing the procedures of licensing of the private activity and of the drug registering, in order to facilitate and ease them.

HEALTH INSURANCE INSTITUTE

Health Insurance in the Republic of Albania has been institutionalized in accordance with the Law “For the Health Insurance in the Republic of Albania” (No. 7870), date 13.10.1994.

It is a Bismarck type Health Insurance scheme started being implemented in March 1st 1995 as one important mechanism in the reforming of the health system, in the financing method and increase of resources for health care as well as in the quality improvement of service quality.

The scheme of health insurance implemented so far insures the coverage of primary health care services, hospital care and covering part of the drug price based on a list of 374 articles.

The development of the Health Insurance Scheme predicts a considerable increase of the Health Insurance Institute role. Health Insurance Institute will become a buying agency of the financing health care services.
HUMAN RESOURCES

The priority of the Ministry of Health is the capacity building of human resources in the health sector. There are 2039 GP’s, 1587 specialized physicians and 12746 nurses who provide health care services in Albania.
THE SOURCES OF PUBLIC FINANCING FOR HEALTH

State budget
- Ministry of Health
- Ministry of Defence (Military hospital)
- Ministry of Justice (Prisons)

The obligatory contribution of health insurance
- Are gathered by Tax Office – HII

Directly payments / co-payments
Other donors

The financing of health care system

[Diagram showing the flow of funding from state budget, health insurance fund, donors/foreign aid, and NGOs to different levels of health care including public health, primary health care, hospital health care, other national health care services, and private clinic services.]
Macroeconomic indicators for health, public sector (mln/lek)

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenditures</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Budget</td>
<td>222,439</td>
<td>232,339</td>
<td>258,816</td>
<td>285,674</td>
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<tr>
<td>Budget for Health</td>
<td>19,312</td>
<td>21,613</td>
<td>23,090</td>
<td>24,104</td>
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<tr>
<td>GDP</td>
<td>750,785</td>
<td>814,797</td>
<td>801,000</td>
<td>880,503</td>
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</table>

Health towards public expenditures (%)

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Viti</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Budget expenditure</td>
<td>8,8</td>
<td>11,5</td>
<td>9,1</td>
<td>8,4</td>
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<tr>
<td>GDP</td>
<td>2,0</td>
<td>3,0</td>
<td>2,0</td>
<td>2,5</td>
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</table>
# Republic of Albania

## Ministry of Health

### Budget of Ministry of Health

<table>
<thead>
<tr>
<th>Year</th>
<th>Salaries (600)</th>
<th>Social Insurance Contributions (601)</th>
<th>Goods &amp; Services (602)</th>
<th>Subvention (603)</th>
<th>Others (604)</th>
<th>Transfer from foreign fund (605)</th>
<th>Transfer to families budget @ Individuals (606)</th>
<th>Non fixed capital expenditures (230)</th>
<th>Fixed capital expenditures (231)</th>
<th>TOTAL</th>
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</thead>
<tbody>
<tr>
<td>2002 (fact)</td>
<td>4,327,789</td>
<td>1,273,586</td>
<td>3,112,796</td>
<td>0</td>
<td>1,572,950</td>
<td>7,736</td>
<td>0</td>
<td>13</td>
<td>972,103</td>
<td>11,371,973</td>
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<td>2003 (fact)</td>
<td>5,639,645</td>
<td>1,557,034</td>
<td>4,549,228</td>
<td>0</td>
<td>3,256,295</td>
<td>26,202</td>
<td>0</td>
<td>80,758</td>
<td>2,722,504</td>
<td>17,831,665</td>
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<tr>
<td>2004 (fact)</td>
<td>5,212,800</td>
<td>1,423,335</td>
<td>3,928,565</td>
<td>0</td>
<td>2,363,035</td>
<td>18,884</td>
<td>0</td>
<td>44,145</td>
<td>3,097,202</td>
<td>16,088,067</td>
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<tr>
<td>2005 (fact)</td>
<td>5,639,645</td>
<td>1,557,034</td>
<td>4,549,228</td>
<td>0</td>
<td>3,256,295</td>
<td>26,202</td>
<td>0</td>
<td>80,758</td>
<td>2,722,504</td>
<td>17,831,665</td>
</tr>
<tr>
<td>2006 (fact)</td>
<td>6,286,351</td>
<td>1,535,566</td>
<td>4,570,291</td>
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<td>2,318,821</td>
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<td>68,334</td>
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<td>2007 (fact)</td>
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<td>1,227,685</td>
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<td>5,545,000</td>
<td>52,600</td>
<td>0</td>
<td>55,551</td>
<td>4,899,449</td>
<td>22,449,000</td>
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<tr>
<td>2008 plan</td>
<td>6,607,000</td>
<td>1,380,000</td>
<td>5,661,400</td>
<td>0</td>
<td>5,967,000</td>
<td>52,600</td>
<td>0</td>
<td>75,644</td>
<td>4,765,364</td>
<td>24,409,008</td>
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</tbody>
</table>
POLICY VISION

The Government of Republic of Albania is committed to undertake a comprehensive health care reform in all its levels followed by a considerable public investment funds.

• The reform just undertaken in primary health care services will combine decentralization with considerable investments in equipments, buildings, human resources from public funds and international partners and also with the extension of health insurance scheme. Modernization of Primary Health Care through a single source financing and autonomy of health care providers will be the base of the reform.

• Hospital care will be developed through the rationalization of hospital network and regionalization and concentration of services with the aim to increase the performance of services provided. As far as the reform in primary health care, the vision of the Albanian Ministry of Health is to incorporate hospital services under health insurance scheme, which has recently started.

• Public health services will be reformed and modernized. Its institutions will be supported with special programs in disease prevention, vaccination, health promotion, drinking water inspection, etc. In strong collaboration with primary and hospital services it will draw and implement national projects for special disease as tumors, heart diseases, AIDS, traumas, etc.

• Particular social groups will enjoy special services and facilities in the tariffs of health services and drugs usage. Will be consider will great priority the health of the mother, child, individuals with limited capabilities, pensioners, etc.

• Attention will be paid also to chronic diseases as cancer, cardiovascular, cerebrovascular, diabetes, hypertension, etc.

• Direct aid to the National Centre of Quality, Safety and Accreditation of Health Institutions and the Centre of Continuous Medical Education to increase their authority.
Appendix H: Schedule of Interviews

AGENDA OF VISIT TO ALBANIA FOR STEPHEN CONNOR
May 10th – May 14th, 2009

Sunday, May 10th

12:40 Arrival at Mother Theresa Airport – Pickup by the foundation driver. Hotel reservation is made at Rogner Hotel

Monday, May 11th

10:00 Meeting at Centre of Applied Nuclear Physics
   With Nikolla Civici - National Liaison Officer

12:30 Meeting at OSFA (Open Society Foundation for Albania) Offices
   With Andi Dobrushi - OSFA Executive Director

15:00 Meeting at Rogner Hotel, Reception Desk
   With Dr. Gazmend Bejtja - Director of Public Health Directorate

Tuesday, May 12th

13:00 Lunch at Rogner Hotel Restaurant
   With Dr. Anshu Banerjee - Head of WHO Country Office

14:30 Meeting at Ministry of Health
   With Dr. Arben Ivanaj - Deputy Minister of Health

Wednesday, May 13th

10:00 Meeting at Sue Ryder Hospice Albania Office
   With Dr. Fatmir Prifti - Director for Albanian office
   and English Representatives from London Office

13:30 Meeting at Oncology Department, Mother Theresa Hospital
   With Dr. Agim Sallaku - Director, Oncology Department, Mother Teresa Hospital

15:00 Meeting at Institute of Public Health
   With Dr. Alban Yiili - Director of Institute of Public Health

Thursday, May 14th

4:55 AM Departure for the Airport

Address of the foundation:
Rr. Qemal Stafa, 120/2
Tel: +355 4 2234 621; 2234 223; Fax: +355 4 2235 855

Contact Persons:
Ilida Bakshevani, Executive Assistant Mob: 0682070771

Rogner Hotel Europapark - Bulvarid Deshmoret e Kombit - AL-Tirana -
Tel. +355 (4) 2235035 · Fax +355 (4) 2235050 · info@tirana.rogner.com
Schedule for Dr. Stephen Connor
Visit to Albania Nov 1-8, 2009

Sunday Nov 1st
Arrive Tirana 12:10 PM cab to Rogner Hotel

Monday Nov 2nd
12 noon – Henrik Zotaj at SOB office
4 PM - Albert Nikolla – Caritas Albania

Tuesday Nov 3rd
11 AM Lorena Kostallari, Senior Operations Officer – Human Development Sector - World Bank, Tirana
12:30 Meet WHO representatives Vasil Miho <miv@euro.who.int>, Zamira Sinoimeri <siz@euro.who.int>
1:30 PM Sue Ryder Office
3:00 OSI Office – Error! Contact not defined.

Wednesday Nov 4th
10:30 Meet Deputy Minister of Health - Dr. Fatbardh Spahia
11ish Director of Finance/Economics – Saimir Kadiu
1 PM MEETING OF THE PALLIATIVE CARE WORKING GROUP at Sue Ryder Office

Thursday Nov 5th
? CONTINUATION OF PC WORKING GROUP

Friday Nov 6th
Travel and Visit to Korce – Irena Laska
Dinner with Carla Alexander

Saturday Nov 7th
1st National Conference on Palliative Care in Albania

Sunday
11:30 AM Depart Tirana
<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Person</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>April 12, 2010</td>
<td>1100-1600</td>
<td>Preparations for meetings</td>
<td>Planning @ hotel</td>
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<tr>
<td>April 12</td>
<td>1600</td>
<td>Blerta</td>
<td>Planning</td>
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<tr>
<td>Tuesday</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>April 13</td>
<td>0915</td>
<td>Meet with Blerta</td>
<td>@COIN</td>
</tr>
<tr>
<td>April 13</td>
<td>11-12</td>
<td>Met with Rudina &amp; Blerta</td>
<td>@COIN</td>
</tr>
<tr>
<td>April 13</td>
<td>1215</td>
<td>Andi Dobrushi</td>
<td>@ OSIAF</td>
</tr>
<tr>
<td>April 13</td>
<td>1250</td>
<td>Dr Kristo</td>
<td>Lunch</td>
</tr>
<tr>
<td>April 13</td>
<td>1400-1800</td>
<td>PCWG</td>
<td>@ Sue Ryder</td>
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<tr>
<td>Wednesday</td>
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<tr>
<td>April 14</td>
<td>1100</td>
<td>East East Coordinator</td>
<td>@OSIAF</td>
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<td>April 14</td>
<td>1130-12:30</td>
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<td>April 14</td>
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<td>Lunch with Irena Laska</td>
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<td>April 14</td>
<td>1400</td>
<td>MOH Cancer Work Group</td>
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<tr>
<td>April 14</td>
<td>1530</td>
<td>Dr. Bulo med school vice dean</td>
<td>@MOH</td>
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<tr>
<td>Thursday</td>
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<tr>
<td>April 15</td>
<td>AM 930</td>
<td>PCWG (Rudina)</td>
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<td>April 15</td>
<td>11?</td>
<td>European Commission</td>
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<tr>
<td>April 15</td>
<td>1200</td>
<td>Dr Tritan Shehu</td>
<td>Parliament</td>
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<tr>
<td>April 15</td>
<td>1400-1900</td>
<td>Dr. Kristo</td>
<td>In Durres</td>
</tr>
<tr>
<td>Friday</td>
<td>0600</td>
<td>Return flight</td>
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