REPORT

MONITORING OF HEALTH SECTOR EXPENDITURE FOR THE FIRST FOUR MONTHS OF 2026



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Acronyms

CHIF	**Compulsory Health Insurance Fund**
GPE	**General Public Expenditure**
GDP	**Gross Domestic Product**
ISSO	**Integrated Sterilisation Services Operator**
LHCU	**Local Health Care Units**
MTBP	**Medium-Term Budget Programme (MTBP)**
MF	**Ministry of Finance**
MHSW	**Ministry of Health and Social Welfare**

Introduction

This report aims to provide a clear and comprehensive overview of public expenditure in the healthcare sector during the first four months of 2026. It analyses actual expenditure for the four-month period, broken down by economic categories and public investment projects/outputs, compared with the initial and revised budgets of the Ministry of Health and Social Welfare.

The main objective of the report is to identify and interpret deviations from planned expenditure, as well as the factors contributing to these deviations across budget programmes related to healthcare and administered by the Ministry. Given that the Ministry of Health and Social Welfare is responsible for two important policy areas-healthcare and social protection—the report focuses exclusively on the healthcare sector, providing a detailed analysis of both financial and non-financial aspects.

The data used to prepare this report were obtained from the official websites of the Ministry of Health and Social Welfare, the Ministry of Finance, and the Compulsory Health Insurance Fund.

The data published by the Ministry of Health and Social Welfare on budget monitoring for the health and social welfare sector are limited and incomplete. Some of the tables and accompanying annexes that are required to be published under Instruction No. 14/2023, “On Standard Budget Monitoring Procedures for Central Government Units,” are missing.

Consequently, in the absence of complete information, the analysis of expenditure performance and the outputs delivered in this sector during the first four months of 2026 remains partial and limited.

1. Healthcare Budget

If we consider only the healthcare sector, expenditure in this sector, including revenues from the Compulsory Health Insurance Fund (CHIF), amounts to ALL 76.6 billion.

This expenditure accounts for 2.9% of GDP and 9.6% of General Public Expenditure (GPE). The data show that functional expenditure on healthcare, in nominal terms, has increased steadily throughout the 2018–2026 period, rising from ALL 49 billion in 2018 to approximately ALL 81.1 billion in 2026.

However, this nominal increase is not reflected in the relative share of healthcare expenditure as a percentage of GDP and total General Public Expenditure (GPE), which has remained broadly unchanged.

This indicates that, although nominal healthcare funding has increased, the sector's relative share of public expenditure has been declining. This supports the aforementioned conclusion regarding the reorientation of public spending towards other priority sectors.

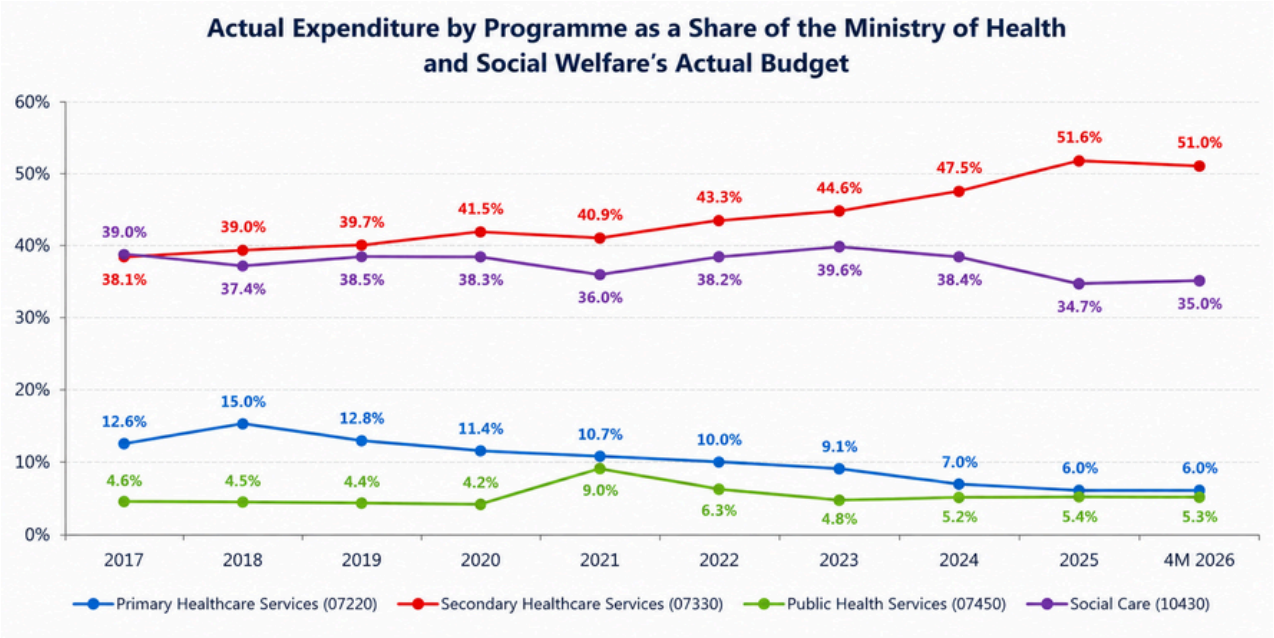
Table 1: Functional Expenditure on Healthcare Over the Years

Indicator	2018	2019	2020	2021	2022	2023	2024	2025	2026
Functional Healthcare Expenditure (ALL million)	49,004	51,182	51,590	63,620	65,501	64,697	69,750	76,637	81,164
Healthcare expenditure as % of GDP	3.00%	3.00%	3.10%	3.40%	3.00%	2.70%	2.80%	2.90%	2.90%
Healthcare expenditure as % of GPE	10.30%	10.40%	9.60%	10.70%	10.10%	9.60%	9.60%	9.60%	9.20%
Nominal GDP (ALL million)	1,660,820	1,712,037	1,655,984	1,866,672	2,149,742	2,364,276	2,517,820	2,642,509	2,781,433
General Public Expenditure (ALL million)	476,147	491,897	536,279	596,279	651,015	674,857	728,572	801,694	886,764

Source: Ministry of Finance and Ministry of Health and Social Welfare

Actual expenditure by the Ministry of Health and Social Welfare's main programmes shows varying trends across healthcare components.

Chart 1: *Share of Actual Expenditure by the Ministry of Health and Social Welfare's Main Programmes in Total Budget Expenditure*



Source: *Ministry of Health and Social Welfare Monitoring Reports over the Years*

Chart 2 highlights a contrast between trends in public expenditure on primary and secondary healthcare over the 2017–2026 period. While the share of expenditure allocated to primary healthcare has halved over the past decade, falling from 12.6% to 6.0%, the share allocated to secondary healthcare has increased from 38.1% to 51.6%. This reflects not merely a change in the budget structure, but also signals a clear shift in the allocation of public funding away from prevention, early intervention and community-based disease management towards treatment at higher, more costly levels of the healthcare system.

In a healthcare system such as Albania's, which aims to prioritise prevention and early intervention, this trend raises significant concerns regarding the efficiency and long-term sustainability of healthcare financing. Reduced investment in prevention and primary healthcare weakens the system's capacity to identify and manage health problems in a timely manner, before they progress and require more complex treatment.

As a result, a greater share of the financial burden and demand for services may gradually shift towards secondary and hospital care, where the treatment of diseases is generally more complex and resource-intensive. In this regard, reducing investment in prevention does not necessarily translate into savings for the healthcare system. On the contrary, it may lead to higher costs in the future, as health conditions that remain unidentified or unmanaged in a timely manner may require specialised treatment and hospital services.

This makes strengthening primary healthcare and ensuring adequate funding a critical factor not only for population health, but also for the long-term efficiency and financial sustainability of the healthcare system.

Furthermore, the reduction in funding for primary healthcare, at a time when new services are being integrated at this level and healthcare providers' responsibilities are expanding, raises significant concerns about the system's actual capacity to deliver these services effectively and with adequate quality. Expanding services without a corresponding increase in funding risks creating a gap between planned policies and the system's capacity to implement them in practice.

An analysis of budget execution for the first four months of 2026 shows that the Ministry of Health and Social Welfare has performed satisfactorily only in current expenditure categories, while investment continues to be characterised by low execution rates. The regular execution of personnel and other current expenditure contrasts with the weak execution of capital expenditure, which reached only 13% of the planned amount. This situation highlights persistent difficulties in implementing public investments and creates a risk of significant project delays or the concentration of expenditure towards the end of the budget year.

Overall, the combination of a relatively declining share of funding and low investment execution rates raises concerns about the sector's capacity to improve the quality, accessibility and sustainability of health and social services. This indicates that the challenge is not limited to the level of available resources, but also concerns the capacity to plan and execute them effectively, thereby limiting the potential of reforms and investments to address the population's growing needs.

1.1 Monitoring the Healthcare Budget

In 2026, the Ministry of Health and Social Welfare administers and manages public funds under seven approved programmes, as follows:

- Planning, Management and Administration
- Primary Healthcare Services
- Secondary Healthcare Services
- Public Health Services
- Social Care
- Rehabilitation of Politically Persecuted Persons

1.1.1 "Primary Healthcare Services" Programme

The Primary Healthcare Programme provides essential health services to the population through family physicians and health centres, including curative and preventive care and health promotion. The programme plays a key role as the first point of contact with the healthcare system, in managing chronic diseases, and in improving access to services and financial protection for citizens. The objective of this budget programme is "Universal coverage of the population's needs for primary medical care."

The programme pursues this budget objective through the following targets:

- Improving preventive services and the early diagnosis of diseases.
- Ensuring that 90% of health centres are equipped with the necessary infrastructure for the operation of the information system.

Expenditure execution for this programme during the first four months of 2026, in Albanian lek (ALL), is presented in the table below.

Table 2: *Expenditure Execution for the First Four Months of 2026 – In ALL*

Programme "Primary Health Care Services" 07220	Initial Annual Plan Year 2026	Revised Annual Plan Year 2026	Annual Plan Change	Actual 4M 2026	Plan-Actual Difference	% Realization
600 Wages	100,955,000	100,955,000	0	32,618,200	68,336,800	32%
601 Social Insurance Contributions	18,090,000	18,090,000	0	5,366,990	12,723,010	30%
602 Other Goods and Services	44,000,000	44,000,000	0	3,760,280	40,239,720	9%
603 Subsidies	0	0	0	0	0	0%
604 Domestic Current Transfers	3,610,880,000	3,610,880,000	0	1,202,914,000	2,407,966,000	33%
605 Foreign Current Transfers	0	0	0	0	0	0%
606 Transfers to Family Budgets and Individuals	0	760	760	98	662	13%
Subtotal - Current Expenditure	**3,773,925,000**	**3,773,925,760**	**760**	**1,244,659,568**	**2,529,266,192**	**33%**
230 Intangible Assets	10,000,000	10,000,000	0	0	10,000,000	0%
231 Tangible Assets	320,253,000	320,253,000	0	0	320,253,000	0%
Subtotal - Capital Expenditure Financed Domestically	**330,253,000**	**330,253,000**	**0**	**0**	**330,253,000**	**0%**
230 Intangible Assets	0	0	0	0	0	0%
231 Tangible Assets	158,000,000	158,000,000	0	6,337,010	151,662,990	4%
Subtotal - Capital Expenditure Financed by Foreign Sources	**158,000,000**	**158,000,000**	**0**	**20,170,010**	**137,829,990**	**13%**
Total Capital Expenditure	**488,253,000**	**488,253,000**	**0**	**20,170,010**	**468,082,990**	**4%**
Total Budget Expenditure of the Programme	**4,262,178,000**	**4,262,178,760**	**760**	**1,264,829,578**	**2,997,349,182**	**30%**

The initial budget allocation for this programme amounted to ALL 4.26 billion, with the largest share of expenditure (84%) accounted for by the budget transfer to the Compulsory Health Insurance Fund (CHIF), amounting to ALL 3.61 billion. The transfer allocated under this programme is intended to cover expenditure on the financing of primary healthcare services, reimbursement of medicines and medical devices included in the reimbursement list, and the concessionary basic medical check-up service (check-up programme). During the first four months of 2026, no significant revisions were made to the budget plan. Regarding actual programme execution, the expenditure execution rate stands at 30%. Current expenditure shows satisfactory performance for the period, while capital expenditure has performed poorly, with an execution rate of only 13% for the sub-category of foreign-funded projects.

According to the Ministry of Health and Social Welfare's four-month monitoring report, these projects are currently undergoing procurement procedures. The programme remains stable in terms of budget planning for its outputs and their implementation. The programme's outputs and investment projects remain consistent with those established by the Ministry of Health and Social Welfare in the 2026–2028 Medium-Term Budget Programme document. No new outputs were introduced during the first four months of 2026. The programme's previously initiated policies continue to be implemented, without substantial changes from previous years. The performance of the outputs financed through this programme's current expenditure is presented below, in both quantitative and financial terms (in ALL), for the first four months of 2026.

Table 3: *Performance of Outputs Financed through Current Expenditure (in ALL)*

Product code	Output	Unit of measurement	Planned quantity	Expenditure under initial budget (ALL)	Planned unit cost (ALL)	Quantity achieved	Expenditure under revised budget (ALL)	Actual unit cost (ALL)	Actual quantity (Jan–Apr 2026)	Actual expenditure (Jan–Apr 2026, ALL)	Unit cost (Jan–Apr 2026, ALL)
91303AA	Number of primary healthcare visits	Number of visits	7,654,548	1,473,945,00	193	7,396,905	1,474,705,000	199	2,513,276	252,743,795	101
91303AB	People benefiting from the basic medical check-up service	Number of people	379,442	699,823,000	1,844	379,442	699,823,000	1,844	177,534	292,014,000	1,645
91303AC	Patients receiving prescriptions for reimbursable medicines issued by family physicians	Patients	400,000	1,600,157,00	4,000	400,000	1,600,157,000	4,000	329,871	700,000,00	2,122

The outputs financed through current expenditure are listed below:

- *Number of primary healthcare visits;*
- *Number of people receiving basic medical check-ups;*
- *Number of patients receiving prescriptions for reimbursable medicines issued by family physicians.*

During the first four months of 2026, the main outputs of the "Primary Healthcare Services" Programme performed as follows:

Table 4: *Performance of Key Outputs Against the 2026 Annual Plan*

Product Code	Output	Expenditure Execution (%)	Quantity Execution (%)
91303AA	Number of primary healthcare visits	17%	34%
91303AB	People benefiting from the basic medical check-up service	42%	47%
91303AC	Patients receiving reimbursable prescriptions issued by family physicians	44%	82%

- The output "Number of primary healthcare visits" achieved 34% of the expected number of beneficiaries, compared with 17% of the expenditure budget allocated to this output.

- The output "People receiving the basic medical check-up service" exceeded the period's average projections, using 42% of the annual allocated budget and reaching 47% of the expected number of beneficiaries.

- The output "Patients receiving prescriptions for reimbursable medicines issued by family physicians" exceeded the period's average projections, using 44% of the annual allocated budget and reaching 82% of the expected number of beneficiaries.

It is worth noting that this monitoring report continues to highlight problems with the inaccurate reporting of funding for the outputs "Number of primary healthcare visits" and "Patients receiving prescriptions for reimbursable medicines," as the data are not reported on a consolidated basis by funding source. These outputs are financed partly through the state budget (the transfer to the Compulsory Health Insurance Fund - CHIF) and partly through revenues from the health insurance scheme. Accordingly, with reference to the 2026-2028 Medium-Term Budget Programme (MTBP) document, the annual targets for the quantities and expenditure allocated to the aforementioned outputs are presented in full below:

Table 5: *Ministry of Health and Social Welfare's 2026–2028 Medium-Term Budget Programme (MTBP), "Primary Healthcare Services" Programme*

Product	91303AA - Number of visits in primary health care		
Product Description	Number of visits in primary health care		
Unit of Measure	Number of visits		
	2026 Forecast	**2027 Forecast**	**2028 Forecast**
Quantity	7,654,458	7,700,385	7,720,000
Total Cost (ALL)	17,823,002,000	16,793,045,000	18,111,200,000
Unit Cost (ALL)	2,328	2,181	2,346
Breakdown of Total Product Cost by Economic Items			
	2026 Forecast	**2027 Forecast**	**2028 Forecast**
600 - Wages	100,955,000	101,255,000	101,885,000
601 - Social Insurance Contributions	18,090,000	18,090,000	18,090,000
602 - Other Goods and Services	43,700,000	43,700,000	50,225,000
604 - Current Transfers	1,310,900,000	2,300,000,000	2,500,000,000
999 - Off-budget	16,349,057,000	14,330,000,000	15,441,000,000
Total Product Cost	**17,823,002,000**	**16,793,045,000**	**18,111,200,000**

As shown, the costs planned in the 2026–2028 Medium-Term Budget Programme for 2026 for the output "Number of primary healthcare visits" amount to ALL 17.8 billion, comprising ALL 16.3 billion in funding from CHIF revenues and ALL 1.4 billion from the state budget.

Table 5.1: *Ministry of Health and Social Welfare's 2026–2028 Medium-Term Budget Programme (MTBP), "Primary Healthcare Services" Programme*

Product	91303AC – Patients receiving reimbursed prescriptions from the family doctor		
Product Description	Patients receiving reimbursed prescriptions from the family doctor		
Unit of Measure	Number of patients		
	2026 Forecast	**2027 Forecast**	**2028 Forecast**
Quantity	400,000	400,000	400,000
Total Cost (ALL)	11,596,100,000	14,537,160,000	14,933,655,000
Unit Cost (ALL)	28,990	36,343	37,334
Breakdown of the Product's Total Cost by Economic Items			
	2026 Forecast	**2027 Forecast**	**2028 Forecast**
604 - Current Transfers	1,600,157,000	3,711,160,000	3,504,655,000
999 - Off-budget	9,995,943,000	10,826,000,000	11,429,000,000
Total Product Cost	**11,596,100,000**	**14,537,160,000**	**14,933,655,000**

Meanwhile, for the output "Patients Receiving Prescriptions for Reimbursable Medicines," the total cost planned for 2026 amounts to ALL 11.56 billion, comprising ALL 1.6 billion in funding from the state budget and ALL 9.9 billion from CHIF revenues. The planned cost in the MTBP document is also inaccurate, as Article 5 of Law No. 87/2025, "On the State Budget for 2026," stipulates that the fund for the reimbursement of medicines must not exceed the ceiling of ALL 13.5 billion, whereas the ceiling planned in the MTBP is ALL 11.59 billion.

MHSW's four-month monitoring report does not include the actual expenditure execution for the output "Number of Primary Healthcare Visits" financed through revenues from the health insurance scheme. This information is also absent from the tables accompanying the monitoring report. Consequently, the actual average cost per visit for the first four months of 2026 is not reported accurately.

For the output "Patients Receiving Prescriptions for Reimbursable Medicines," actual expenditure for the first four months, including revenues from the health insurance scheme, is reported in the explanatory section of the monitoring report at ALL 4.47 billion, representing 35% of the approved annual budget of ALL 13.5 billion. The data presented in the official tables above provide a different picture from that described in the explanatory section of the budget requirements report, resulting in inaccuracies in the reporting of costs and the number of beneficiaries. In addition to the problems with inaccurate cost reporting for patients, as outlined above, the monitoring report provides information on funding and beneficiaries only for expenditure on the reimbursement of blood glucose test strips for diabetes, which amounted to ALL 54.8 million out of the planned ALL 166 million, or 34% of the annual budget, covering 47,334 patients.

It also reports expenditure of ALL 23.4 million for the reimbursement of stoma care packages, representing 32% of the annual budget, with 540 beneficiaries.

Meanwhile, explanatory information continues to be lacking regarding other categories of beneficiary patients and the types of medicines covered. With regard to reimbursable medicines, the report refers to the legislation under which the reimbursement lists were approved but does not analyse how these lists will address the identified needs and challenges of patients receiving primary and hospital care.

Under these circumstances, it is not possible to determine which beneficiary categories account for the largest share of expenditure under the reimbursement scheme or how disease prevalence indicators influence expenditure trends.

Regarding the output "People Receiving the Basic Medical Check-up Service," it should be noted that expenditure has been planned for the duration of the concession contract and is paid in accordance with the contractual terms, based on the ceiling for the number of beneficiaries established under the concession agreement. During the first four months of 2026, 177,534 patients benefited from the check-up service, out of the 379,442 planned under the contractual terms. The Ministry of Health and Social Welfare has not clarified in its monitoring report how the service will continue once the concession contract expires. The publication of inaccurate information, combined with the weak supporting analysis provided in the report, creates a distorted picture of programme performance, significantly undermining budget transparency and the quality of institutional monitoring.

In the long term, the lack of reliable analysis of the performance of key primary healthcare outputs and the impact of the reimbursement scheme risks leading to suboptimal decision-making, inefficient allocation of public funds, and widening inequalities in access to healthcare services. This situation weakens institutional transparency and accountability, limits the capacity for evidence-based planning, and undermines the financial sustainability of the healthcare system.

The outputs financed through capital expenditure are primarily related to projects for the reconstruction of health centres and polyclinics, as well as equipping them with the necessary medical equipment. The following table presents investment projects financed through domestic and foreign funding, according to the initial budget allocation, the revised budget allocation, and actual expenditure execution.

1.1.2 "Secondary Healthcare Services" Programme

This programme ensures the timely and quality delivery of hospital services throughout the country in a coordinated and equitable manner, with the aim of reducing mortality and disability rates. The objectives of this budget programme are "Universal coverage of the population's needs for specialised medical care" and *"Ensuring an effective central-level emergency medical service that responds to the needs of the population."

The programme pursues these budget objectives through the following targets:

- Providing high-quality and comprehensive secondary healthcare services.
- Ensuring an effective central-level emergency medical service that responds to the needs of the population.
- Meeting 100% of citizens' needs for telephone assistance in emergency situations where their lives are at risk.

Expenditure execution for this programme during the first four months of 2026 is presented in the following table:

Table 6: *Expenditure Execution for the First Four Months of 2026 (in ALL)*

Code	Programme "Secondary Health Care Services" 07330	Initial Annual Plan Year 2026	Revised Annual Plan Year 2026	Annual Plan Change	Actual 4M 2026	Plan-Actual Difference	% Realization
600	Wages	1,111,745,000	1,111,745,000	0	334,469,060	777,275,940	30%
601	Social Insurance Contributions	189,830,000	189,830,000	0	55,018,030	134,811,970	29%
602	Other Goods and Services	1,359,000,000	1,359,000,000	0	362,561,450	996,438,550	27%
603	Subsidies	0	0	0	0	0	0%
604	Domestic Current Transfers	37,375,864,000	37,375,864,000	0	10,908,817,060	26,467,046,940	29%
605	Foreign Current Transfers	0	0	0	0	0	0%
606	Transfers to Family Budgets and Individuals	0	1,232,000	1,232,000	306,500	925,500	25%
	Subtotal - Current Expenditure	**40,036,439,000**	**40,037,671,000**	**1,232,000**	**11,661,172,100**	**28,376,498,900**	**29%**
230	Intangible Assets	40,000,000	0	-40,000,000	0	0	0%
231	Tangible Assets	2,865,860,000	2,705,860,000	-160,000,000	103,175,390	2,602,684,610	4%
	Subtotal - Capital Expenditure Financed Domestically	**2,905,860,000**	**2,705,860,000**	**-200,000,000**	**103,175,390**	**2,602,684,610**	**4%**
230	Intangible Assets	0	0	0	8,505,010	-8,505,010	0%
231	Tangible Assets	547,500,000	547,500,000	0	168,710,070	378,789,930	31%
232	Capital Transfers	0	200,000,000	200,000,000	200,000,000	0	100%
	Subtotal - Capital Expenditure Financed by Foreign Sources	**547,500,000**	**547,500,000**	**0**	**177,215,080**	**370,284,920**	**32%**
	Total Capital Expenditure	**3,453,360,000**	**3,453,360,000**	**0**	**480,390,470**	**2,972,969,530**	**14%**
	Total Budget Expenditure of the Programme	**43,489,799,000**	**43,491,031,000**	**1,232,000**	**12,141,562,570**	**31,349,468,430**	**28%**

The initial budget allocation for the "Secondary Healthcare Services" Programme amounted to ALL 43.5 billion, of which 92.7% of total expenditure consisted of domestic current transfers amounting to ALL 37.4 billion, primarily intended to finance the operations of secondary healthcare institutions. The remainder of the budget comprised personnel expenditure of ALL 1.3 billion, operating expenditure on goods and services amounting to ALL 1.4 billion, and capital expenditure of ALL 3.5 billion.

During the monitoring period, the annual budget was revised only marginally, with a net increase of just ALL 1.2 million, related to transfers to households and individuals. Meanwhile, funding for domestically financed capital investments was reduced by ALL 200 million, while an allocation of ALL 200 million was introduced for capital transfers. As a result, the programme's total budget remained virtually unchanged compared with the initial allocation. The capital transfer represents funding allocated by the Ministry of Health and Social Welfare as the initial capital contribution for the establishment and operation of the state-owned joint-stock company Integrated Sterilisation Services Operator (OSHIS sh.a.), approved by Council of Ministers Decision No. 845, dated 30 December 2025, as amended.

During the first four months of 2026, actual expenditure under the programme amounted to ALL 12.1 billion, equivalent to 28% of the revised annual budget. Current expenditure execution stood at 29%, while capital expenditure execution remained considerably lower, at just 14% of the annual allocation. Within this category, domestically financed investments achieved an execution rate of 4%, while foreign-funded investments reached 32%.

Capital investment performance, particularly for domestically financed projects, remains weak, with only ALL 103.2 million executed against an annual allocation of ALL 2.7 billion. The monitoring report provides an analysis of the status of most investment projects under this programme. A synthesis of the reported data indicates that physical progress has been made on some ongoing projects, despite invoices remaining unpaid. Meanwhile, most new investment projects scheduled to commence in 2026 are still undergoing tendering procedures or appeals before the Public Procurement Commission.

A new development in the planning of domestically financed investments under this programme is the reallocation of ALL 200 million from domestically financed investment projects to the capital transfer item (232). The monitoring report does not explain the rationale for this reallocation, although it appears that the funds have been used to finance the initial capital of the newly established joint-stock company, OSHIS, which is wholly state-owned. At the same time, the relatively low execution rate for current expenditure (29%) highlights the need for continuous monitoring of the pace of budget execution during the remainder of the year, in order to avoid the concentration of expenditure towards the end of the budget year.

Table 7: *Performance of Outputs Financed by Current Expenditure – in ALL*

Product Code	Product Name	Unit of Measure	Initial Plan - Quantity	Initial Plan - Budget	Cost per Unit	Revised Plan - Quantity	Revised Plan - Budget	Cost per Unit	Actual Quantity	Actual Expenditure	Cost per Unit
91303AB	Patients treated in inpatient hospital services	Inpatient	322,316	30,911,769,000	95,906	322,316	30,911,769,000	95,906	111,200	9,785,553,116	88,003
91304AB	Patients receiving dialysis treatment	Nephrology	217,605	2,650,000,000	12,178	217,605	2,650,000,000	12,178	71,237	940,000,000	13,195
91304AC	Patients treated in psychiatric hospitals	Psychiatry	924	1,156,870,000	1,251	924	1,156,870,000	1,251	701	362,324,629	517,602
91304AD	Patients treated under cardiology and cardiac surgery packages	Cardiology	11,930	1,493,567,000	125,194	11,930	1,493,567,000	125,194	4,204	64,998,128	15,461
91304AE	Patients treated with organ transplants	Transplant	22	23,310,000	1,059,545	22	23,310,000	1,059,545	0	7,000,000	-
91304AF	Patients treated for cataracts	Cataracts	5,147	102,048,000	19,815	5,147	102,048,000	19,815	440	115,297,900	26,359
91304AG	Patients treated with radiotherapy	Radiotherapy	31,285	137,654,000	4,400	31,285	137,654,000	4,400	8,938	-	-
91304AH	Patients with Down syndrome	Down syndrome	1,250	6,048,000	4,838	1,250	6,048,000	4,838	16	0	0
91304AI	Laboratory examinations	Laboratory	5,299,035	2,000,000,000	377	5,299,035	2,000,000,000	377	1,733,622	441,577,397	255
91304AJ	Patients treated through EQMZH HF	Service	450	121,084,000	269,076	450	121,084,000	269,076	345	33,924,519	98,331
91304AM	Reimbursed medicines and medical devices	Reimbursement	3,630	236,885,000	64,371	3,630	236,885,000	64,371	1,690	51,863,506	30,698
91304AN	Home-based palliative care	Palliative care	378	65,000,000	171,958	378	65,000,000	171,958	1,112	118,890,358	106,918
91304AP	Cases treated by emergency medical units	Emergency	120,000	574,714,000	4,789	120,000	574,914,000	4,791	46,885	83,783,260	1,787
91304AQ	Patients treated with breast reconstruction surgery (breast prosthesis)	Breast reconstruction	50	70,000,000	1,400,000	50	70,000,000	1,400,000	0	0	0
91304AR	Patients treated with corneal procedures	Cornea	200	25,000,000	125,000	200	25,000,000	125,000	0	0	0
91304AT	Patients treated with thrombectomy procedures	Thrombectomy	300	480,000,000	1,600,000	300	480,000,000	1,600,000	0	0	0

Source: *MSHMS, First Four-Month Monitoring Report, 2026*

Overall, the performance of the Secondary Healthcare Services Programme in the first four months of 2026 shows varying levels of execution. However, the analysis of outputs reveals significant weaknesses in cost planning, consistency between physical and financial execution, and the quality of performance reporting. For the main output, "Patients Treated in Hospital Services," physical execution stands at 34% and financial execution at approximately 31%, which are broadly in line with the monitoring period. Meanwhile, the actual cost per patient is approximately 8% lower than the planned cost.

A notable finding is the significant variation in the unit cost of this service, which decreased from a planned average cost of ALL 95,906 per patient to an actual unit cost of ALL 88,003, approximately 8% below the planned level. The official data published by the Ministry of Health and Social Welfare (MHSW) do not provide any explanation for the variation in unit cost or justify the reduction.

The total cost of this output also includes payments to the concessionaire for sterilisation services. For 2026, these payments were planned to be made until 8 March, the date on which the concession contract expired. According to MHSW, actual expenditure on this service in 2026 amounted to ALL 582.8 million, against the planned ALL 700 million. MSHMS states that the remaining ALL 117.2 million may be used to meet the needs of hospital services. According to MSHMS, as of 9 March 2026, integrated sterilisation services have been provided by the Integrated Sterilisation Services Operator (ISSO sh.a.), with which hospitals have signed contracts to ensure the continuation of the service.

However, the Ministry of Health and Social Welfare (MHSW) does not provide sufficient information or analysis on the delivery of sterilisation services, the performance of the concession contract during its implementation, or, in particular, the arrangements surrounding its expiry. There is also no clear justification for the decision to transfer the provision of this service from a public-private partnership (PPP) model to a joint-stock company with 100% state ownership.

The information presented in the explanatory note accompanying the monitoring report on this initiative is limited and does not allow for a comprehensive assessment of the financial, organisational and operational implications of changing the service management model. In particular, no data are provided on the budget allocated for the operation of the service, funding sources, expected operating costs, or the mechanisms through which the Integrated Sterilisation Services Operator (OSHIS) will secure its funding.

Furthermore, the future reporting, monitoring and accountability mechanisms for this service remain unclear, particularly given that it will be managed by a joint-stock company. The absence of these elements limits the ability to assess the financial sustainability of the new model, its impact on service quality and efficiency, and the potential risks to the state budget.

Consequently, the current reporting does not provide the necessary transparency to determine whether the transition from a concession arrangement to a state-owned joint-stock company represents the most effective and cost-efficient alternative for delivering sterilisation services. The lack of an evidence-based financial and performance analysis undermines accountability and makes it difficult to assess the results expected from this institutional change.

The output "Patients Receiving Dialysis Treatment" recorded 71,237 sessions against 217,605 planned, while actual expenditure amounted to ALL 940 million, compared with the planned ALL 2.65 billion. In terms of both the number of sessions delivered and financial execution, performance appears to be within the expected range for the monitoring period.

This service is financed directly from the state budget through public hospitals, through a public-private partnership (PPP), under which payments are made based on the actual number of sessions, and through the financing of service packages provided by private hospitals. However, the actual expenditure reported by MSHMS in the report, broken down by these three funding sources (ALL 766.9 million), does not match the actual expenditure figure calculated on the basis of the unit cost and the number of sessions delivered (ALL 940 million).

The output **"**Patients Treated in Psychiatric Hospitals" recorded 701 patients treated during the first four months of 2026, against a target of 924 patients, approximately 24% below the planned target. An annual budget of ALL 1.15 billion was allocated for this output, of which approximately 30% had been spent by the end of the reporting period. This level of execution is considered to be within the normal range for the period.

However, an analysis of the indicators reveals significant discrepancies between physical and financial execution. While the number of patients treated was 223 below the target, the unit cost of the service deviated by approximately 58% from the planned value. This situation suggests that the planned cost per patient was not based on realistic assumptions and data regarding service workload and expenditure structure.

Consequently, the output exhibits clear weaknesses in the planning and reporting of the unit cost of the service, limiting the ability to accurately assess the efficiency of fund utilisation and the actual performance of psychiatric hospitals. The Ministry should provide more detailed analyses of the factors that have influenced deviations in the number of patients treated and changes in the average cost per patient, in order to improve budget planning and monitoring of this service.

The output "Patients Treated under Cardiology and Cardiac Surgery Packages" recorded 4,204 patients treated during the first four months of 2026, against an annual target of 11,930 patients, representing approximately 35% of the planned target.

An annual budget of ALL 1.5 billion was allocated for this output, while actual expenditure reported by the end of the period amounted to only 4% of the planned allocation.

The data analysis shows that, although the number of patients treated reflects an execution level that does not deviate to the same extent from the expected time profile of the annual target, reported expenditure is significantly lower than anticipated for the level of activity delivered. Consequently, the unit cost of the service is approximately 87% below the planned level for the period.

This situation raises concerns about the realism and accuracy of service cost planning, while potentially also indicating problems in reporting expenditure associated with this output. The substantial discrepancy between physical and financial execution makes it difficult to assess the efficiency of fund utilisation and analyse the actual cost per patient. In the absence of an explanatory analysis from the Ministry, it is not possible to determine the reasons for this significant deviation. A more detailed analysis is therefore needed of the methodology used to plan the cost per patient, the structure of expenditure included under this output, and the reasons for the very low level of financial execution relative to the reported volume of services delivered.

The output "Patients Treated for Cataracts" recorded 440 patients treated during the first four months of 2026, against an annual target of 5,147 patients, representing approximately 8% of the planned target. An annual budget of ALL 112 million was allocated for this output, while actual expenditure reported by the end of the period amounted to only 10% of the planned allocation.

The monitoring report does not explain the reasons for the low level of output achievement during the reporting period.

The outputs "Patients Treated under the Kidney Transplant Package" and "Patients Treated with Radiotherapy" exhibit significant shortcomings in data reporting, limiting the ability to assess performance and the efficiency of public fund utilisation.

Specifically, for the output "Patients Treated under the Kidney Transplant Package," no achieved quantity is reported, although actual expenditure of ALL 7 million is recorded against an annual allocation of ALL 23.3 million. The absence of quantitative reporting makes it impossible to assess the cost per patient and analyse the extent to which the output's targets have been achieved.

Conversely, for the output "Patients Treated with Radiotherapy," the report records 8,938 patients treated against an annual target of 31,285, while no actual expenditure is reported for the period. This discrepancy between physical and financial reporting raises concerns about the accuracy and completeness of the reported data, making it difficult to analyse the cost of the service and assess the financial efficiency of the output.

The output "Patients with Down Syndrome" was included in the initial 2026 budget with a target of 1,250 tests. However, only 16 tests are reported as having been performed during the first four months of the year, while no actual expenditure is reported for this output. We consider that the Ministry's reporting contains inaccuracies that also prevent an adequate analysis of this output.

The programme also finances the concession contract for laboratory services, associated with the output "Laboratory Tests." According to the reported data, approximately 1.7 million laboratory tests were performed during the first four months of 2026, against an annual target of 5.3 million tests. Expenditure amounted to ALL 441 million, compared with the ALL 2 billion allocated for 2026.

Although the physical and financial execution of this output appears to be broadly in line with the expected pace for the reporting period, the monitoring report notes that the Administrative Council of the Compulsory Health Insurance Fund (CHIF) approved the allocation of ALL 100 million from the reserve fund to meet hospitals' increasing demand for this service. However, this additional funding is not reflected in the monitoring tables presented by the Ministry of Health and Social Welfare (MHSW), creating uncertainty regarding its allocation, use and impact on the delivery of the output.

Furthermore, the report does not provide sufficient information on the performance of the concession contract during the monitoring period. In particular, it lacks data and analysis on the extent to which the concessionaire has met its performance indicators, the quality and volume of services delivered, the difficulties encountered by hospitals in accessing the service, and the factors driving the increased need for additional funding.

Consequently, the reporting remains incomplete and does not allow for a comprehensive assessment of the effectiveness of public fund utilisation or the performance of the concession contract. MHSW should provide more detailed analyses of the contract's implementation, the reasons for the request for additional funding, and the impact of this service on improving access to and the quality of healthcare provided to patients.

During the first four months of 2026, the output "Couples Benefiting from the Fertility Package" recorded 32 patients treated, with an average treatment cost of ALL 36,543 per patient, compared with a planned average cost of ALL 187,500 per treatment. The report does not explain the reasons for this substantial deviation in the unit cost of treatment.

The monitoring report also includes three new outputs under this programme, introduced as funded policy measures during the preparation of the 2026 budget: "Patients Undergoing Breast Reconstruction Surgery (Breast Implants)," with a total planned allocation of ALL 1.4 million; "Patients Treated through Corneal Transplantation," with an allocation of ALL 24 million; and "Patients Treated through Thrombectomy," with an allocation of ALL 480 million. No actual implementation of any of these three outputs was reported during the four-month period.

Meanwhile, MHSW has provided no justification for their non-implementation.

The programme also finances the national emergency medical service, which has been integrated into the healthcare system's financing framework since 2023. For 2026, the target is to handle 120,000 cases through emergency medical units, with a total budget allocation of ALL 547 million.

During the first four months of the year, approximately 46,000 calls were handled, representing around 39% of the annual target. However, actual expenditure amounted to ALL 83.7 million, or only 14% of the planned allocation.

The data analysis reveals a clear discrepancy between the physical delivery of the service and its financial execution. While the volume of cases handled represents a relatively high level of achievement for the reporting period, reported expenditure remains significantly below the level expected for this volume of activity. Consequently, the average cost per case handled is substantially lower than planned.

In the absence of explanatory analysis in the monitoring report, it remains unclear whether this situation is attributable to delays in settling expenditure, problems with cost allocation and reporting, or shortcomings in the initial planning of service costs. This discrepancy limits the ability to accurately assess the efficiency of fund utilisation and the actual costs of delivering the national emergency medical service.

Projects financed through capital expenditure show low execution rates for the four-month reporting period. A total of 61 public investment projects were planned, with an overall allocation of ALL 3.4 billion. However, actual expenditure was reported for only six projects, amounting to a total of ALL 280 million. In addition, a capital transfer of ALL 200 million was made to the newly established joint-stock company, OSHIS.

Among these six projects, the one with the highest actual expenditure was the foreign-funded project "Health System Improvement," financed through a World Bank loan, with total expenditure amounting to ALL 167 million.

Table 8: *Investments under the "Secondary Healthcare Services" Programme with Actual Expenditure in the First Four Months of 2026*

Product Code	Product Name	Unit of Measure	Initial Quantity	Initial Plan	Cost per Unit	Revised Quantity	Revised Expenditure	Cost per Unit	Actual Quantity	Actual Expenditure	Cost per Unit
18BB043	Reconstruction of the central hospital building in Gjirokastër	m²	1,650	122,422,405	74,195	1,650	122,422,405	74,195	669	49,665,790	74,239
22AC653	Supervision and acceptance of the reconstruction of several pavilions at Berat Hospital	No. of services	1	1,120,000	1,120,000	1	1,120,000	1,120,000	–	1,120,000	0
KM13021	Improvement of the health system	–	–	–	0	–	–	0	–	167,128,770	0
18BB189	Supply of equipment for the first phase of interventions at the University Obstetric-Gynecological Hospital "Queen Geraldine"	No. of items	250	150,000,000	600,000	220	117,674,845	534,886	20	4,320,000	216,000
18BB404	Diagnosis of infections at University Hospital Center "Shefqet Ndroqi"	–	1	147,500,000	147,500,000	1	147,500,000	147,500,000	1	10,086,310	10,086,310
22AC641	Construction of several new buildings for the psychiatric hospital in Elbasan	m²	1,348	129,963,317	96,412	1,348	129,963,317	96,412	–	48,069,600	0
	TOTAL			**551,005,722**			**518,680,567**			**280,390,470**	

PThe next project with notable financial performance during the first four months of the year was "Reconstruction of the Main Building of Gjirokastër Hospital." This ongoing project, which began in 2025, has a total investment value of ALL 419 million. According to MSHMS, the project is expected to be completed in 2027, while physical implementation of the works has reached 80%.

The project "Construction of Several New Buildings for Elbasan Psychiatric Hospital," initiated in 2024, has also made physical progress, with 48–50% of the works completed. Meanwhile, financial disbursements amounted to ALL 48 million, compared with the planned allocation of ALL 129 million.

The remaining projects planned under this programme show no financial execution. The analysis indicates that, of the total ALL 2.8 billion allocated under the revised budget, the funds have been distributed as follows:

- Renovation of central and regional hospitals: ALL 1.2 billion;
- Medical equipment for central and regional hospitals: ALL 1.02 billion;
- Frozen allocation (Oncology Hospital): ALL 375 million;
- Capital injection for OSHIS: ALL 200 million.

During the first four months of 2026, several budget reallocations appear to have been made. An analysis of the monitoring report indicates that certain projects initially included in the budget were subsequently allocated reduced funding during the budget revision process.

Specifically, the following projects and allocations were revised to zero:

- Reconstruction of the four-storey building of the Psychiatric Clinic at the University Hospital Centre "Mother Teresa" (QSUT): an initial 2026 allocation of ALL 36.6 million;
- Supervision and technical inspection of the reconstruction of the four-storey psychiatric building at QSUT: an initial allocation of ALL 500,000;
- Reconstruction of Tropojë Hospital: an initial 2026 allocation of ALL 44 million;
- Supervision and technical inspection of the reconstruction of Tropojë Hospital: an initial 2026 allocation of ALL 640,000;
- Frozen allocation: ALL 58.4 million;
- Frozen allocation (local costs for PET-CT): ALL 100 million.

The MSHMS monitoring report provides no analysis of the budget reallocations carried out during the reporting period, making it difficult to assess the reasons for and the need to change financial priorities just four months after the approval of the 2026 budget.

The available information indicates that only the frozen allocation of ALL 100 million for the project "Local Costs for PET-CT" was reallocated to the project "Local Costs for PET-CT ANEA", while the remaining funds, including frozen allocations, appear to have been used to finance the capital injection into OSHIS.

However, the lack of information and explanations in the report prevents full verification of these financial transfers. This situation raises serious concerns about the quality of capital investment planning, as projects that were detailed and funded under the initial budget underwent substantial changes within the first months of the budget year. At the same time, the lack of transparency and analysis regarding these reallocations limits the ability to assess whether the changes resulted from new needs, implementation delays, or unrealistic investment planning at the budget formulation stage.

Under the hospital reconstruction category, the 2026 budget provides for hospital healthcare facilities in the districts of Tirana, Fier, Vlorë, Gjirokastër, Korçë, Pogradec, Berat, Has, Mat and Kukës.

The monitoring report on secondary healthcare services remains insufficient as a tool for assessing the effectiveness of public spending. Although MHSW has made some efforts to analyse investment progress and identify implementation challenges, reporting remains largely descriptive and financial, with limited links between budget execution, physical progress and measurable improvements in hospital services. The lack of a comprehensive analysis of budget reallocations, frozen funds and investment outcomes also raises concerns about transparency and the quality of capital investment planning.

Consequently, the report does not provide sufficient evidence to determine whether public funds are being used efficiently or delivering the intended improvements in access to, quality of, and efficiency of hospital care.

1.1.3 "Public Health Services" Programme

Public health services are delivered through national programmes for immunisation, tuberculosis (TB), HIV/AIDS and sexually transmitted infections (STIs), epidemiological surveillance and the monitoring of infectious diseases, as well as chronic diseases with public health implications associated with environmental conditions.

The programme also covers food safety, drinking water quality control and reproductive health. The overall objective of the programme is to "Protect health and promote healthy living."

This objective is pursued through the following targets:

- Maintaining 95% vaccination coverage for vaccines included in the national immunisation schedule;

- Reducing the number of epidemic outbreaks;

- Ensuring that health inspectorates conduct inspections in accordance with the relevant standards;

- Screening approximately 5,000 women for breast cancer and 12,500 women for cervical cancer.

The initial budget allocation for this programme was ALL 4.9 billion, with personnel expenditure accounting for the largest share, at ALL 3.7 billion. Under the domestic and foreign current transfers budget line, funding is allocated to the immunisation programme for children aged 0–18 and to the seasonal influenza vaccine.

During the first four months of 2026, the budget was revised upwards by ALL 7 million under the budget line "Transfers to Household Budgets and Individuals." The MHSW monitoring report for the first four months of 2026 does not provide any justification for this change to the programme's budget.

The programme's capital expenditure allocation stands at ALL 65.9 million, with no actual expenditure recorded during the first four months of 2026. The programme demonstrates consistency in budget planning for its outputs and their implementation in relation to both current and capital expenditure. The programme's outputs remain unchanged and are aligned with those established by the MHSW in the 2026-2028 Medium-Term Budget Programme (MTBP). No new outputs were introduced during the first four months of 2026.

A total of 72,000 children aged 0-18 were vaccinated, out of 180,000 planned for 2026, with expenditure amounting to ALL 17.8 million against a budget allocation of ALL 270.67 million. This represents 40% of the planned number of beneficiaries, while only 7% of the allocated budget was spent during the first four months. As a result, the unit cost decreased from ALL 1,504 per beneficiary to ALL 248 per beneficiary. This indicates an inconsistency between the planned output volume and actual implementation, resulting in an unrealistic unit cost for this output.

- Epidemiological situation monitoring: A total of 1,341 checks were conducted out of 4,650 planned, with expenditure amounting to ALL 914.8 million against ALL 3.1 billion allocated under the revised budget.

- Health inspections: Health inspectorates conducted 6,811 checks and inspections out of 20,000 planned, spending ALL 168.7 million against ALL 562.8 million allocated under the revised 2026 budget.

- Breast cancer screening: A total of 2,329 women were screened out of 5,000 planned, with expenditure amounting to ALL 3.5 million against the ALL 13 million allocated in the 2026 budget. While 40% of the planned screenings were completed, budget execution stood at 27%. This level of execution points to potential weaknesses in budget planning, resulting in an unrealistic unit cost for this output.

- Inspections of hospital units: The National Health Care Operator conducted 183 inspections of hospital units out of 900 planned, spending ALL 113.7 million against ALL 352.5 million allocated in the 2026 budget. The inconsistency between planned and actual output volumes persists, as in the previous two years, raising questions about the reliability of the unit cost estimates for this output.

- A total of 2,273 women were screened for cervical cancer out of the 12,500 planned, with expenditure amounting to ALL 8.7 million against the ALL 26.9 million allocated in the 2026 budget.

A total of 4,070 people were vaccinated against seasonal influenza out of the 280,000 planned, with expenditure amounting to ALL 85 million against the ALL 159.7 million allocated in the 2026 budget. An inconsistency is evident between the planned and actual output: 50% of the allocated funds had been spent, while the number of people vaccinated represented only 1% of the annual target.

- Accreditation of healthcare institutions: A total of 9 healthcare institutions were accredited out of the 70 planned, with expenditure amounting to ALL 16.6 million against the ALL 73.5 million allocated in the 2026 budget.

- Licensing of entities authorised to cultivate cannabis for medical and industrial purposes: The initial budget allocation for this output was ALL 85 million, which increased to ALL 104.9 million under the revised budget. Actual expenditure amounted to ALL 30.8 million. However, inaccuracies persist in the unit of measurement used for the main output. The report clarifies that no entities have been licensed in 2026 and that the output quantity will be determined once the first inspections begin. The monitoring report does not analyse or explain the institution's performance. Furthermore, in line with the monitoring report template, no concrete work outputs have been reported, despite the institution having been established three years ago.

Regarding public investment planning, five projects were budgeted for, with a total allocation of ALL 65.9 million. The two projects with the largest allocations, amounting to ALL 41.8 million and ALL 15.4 million, respectively, are "Supply and Installation of Medical Equipment for Healthcare Institutions" and "Construction of the New ISHP Laboratory Building." The investment portfolio also includes a project labelled "Frozen Allocation," amounting to ALL 3.13 million. This indicates that the institution has included an unspecified allocation within the programme, highlighting weaknesses in the quality of public investment planning.

Regarding the financial performance of investment projects during the first four months of 2026, no expenditure execution was recorded. The MHSW monitoring report does not provide a reasoned explanation for the poor performance of the programme's investment projects. It merely states that the two largest projects are undergoing technical acceptance procedures and goods delivery, and that financial execution will take place once these processes have been completed.

It is concluded that the quality of budget planning and monitoring for this programme remains insufficient to enable a comprehensive assessment of the performance and effectiveness of the policies financed.

1.1.4 Non-Financial Performance and Policy Outcomes of Healthcare Programmes

The monitoring presented by the Ministry of Health and Social Welfare continues to focus primarily on the financial execution of expenditure, while a structured analysis of the results achieved, outputs delivered and their contribution to meeting budget programme objectives is lacking. An analysis of the health sector monitoring report for the first four months of 2026 reveals a complete absence of reporting formats and analysis of performance indicators at the programme objective level. This shortcoming is particularly concerning, given that reporting on these indicators is an explicit requirement under the Ministry of Finance's standard guidelines for monitoring budget programmes.

The report argues that the lack of data is attributable to INSTAT's failure to publish the relevant indicator values. However, MHSW has repeatedly used this justification, not only in its four-month monitoring reports but also in its annual monitoring reports, indicating that the lack of performance information has become a structural problem in the reporting process. As a result, monitoring is reduced to a financial reporting exercise, without providing any assessment of public policy outcomes or the effectiveness of budget expenditure.

This situation significantly undermines the purpose of the budget planning process, as performance indicators are identified and approved during the preparation of the 2026-2028 Medium-Term Budget Programme (MTBP), but are subsequently neither monitored nor reported. Consequently, a clear disconnect emerges between policy planning and monitoring, making it impossible to assess whether allocated funds have produced the intended results and impacts. Under these circumstances, the monitoring process remains largely a formal exercise and fails to fulfil its primary function as a mechanism for measuring performance, ensuring accountability and supporting informed decision-making.

Finally, insufficient cooperation and coordination are evident between MHSW and its key subordinate institutions, including the Compulsory Health Insurance Fund, university hospitals and regional hospitals.

Information on budget implementation, results achieved and challenges encountered by these institutions is presented in an overly brief and descriptive manner, without sufficient analysis of performance, the efficiency of public fund utilisation or the impact of expenditure on improving healthcare services. This limits reporting transparency and makes it difficult to identify the underlying issues requiring intervention by the Ministry's management and policymakers. In the absence of more detailed, results-based reporting, it remains difficult to assess whether public resources are being used effectively to address the healthcare sector's priority needs.

Key findings

1

Limited Reporting on Performance and the Use of Public Funds

The MHSW reports primarily financial data, while analysis of programme performance, service delivery outcomes and investments remains limited. This weakens transparency and accountability regarding how public funds are translated into services and tangible results.

2

Shift in Funding from Prevention and Primary Healthcare Towards Hospital-Based Treatment

The structure of healthcare expenditure indicates a shift in funding away from prevention, early diagnosis and disease management at the primary healthcare level towards secondary and hospital-based care. If this trend continues, it risks weakening the role of primary healthcare and increasing the need for more specialised and costly treatments, thereby placing growing pressure on public healthcare expenditure in the future.

3

Significant Deviations Between Planned and Actual Costs in Hospital Services

Significant discrepancies are evident in the unit costs of key hospital services. The unit cost of psychiatric care was 58% below the planned level, while cardiology and cardiac surgery packages delivered approximately 35% of the planned annual service volume but used only 4% of the annual budget, resulting in unit costs around 87% below projections. The report provides insufficient explanations for these discrepancies and similar deviations across other outputs.

4

Significant Discrepancies Between Services Delivered and Reported Expenditure

The report identifies significant discrepancies between actual service delivery and reported expenditure. For renal transplants, actual expenditure is reported without any corresponding procedures being recorded, while radiotherapy services are reported as delivered despite no actual expenditure being reported.

5

The Transition from the Sterilisation Concession to OSHIS Lacks Transparency Regarding the Actual Cost of the New Model

Following the termination of the sterilisation concession contract on 8 March 2026, the service continued under OSHIS, with hospitals beginning to make payments for the service. MSHMS also provided OSHIS with ALL 200 million in capital funding. However, public reporting does not yet provide a consolidated overview of initial funding, hospital payments, operating costs, investments and service volumes, preventing a comprehensive assessment of the new model's actual cost.



Recommendations

Recommendation1:

Review the Methodology for Planning Unit Costs

MHSW should review its methodology for determining unit costs, ensuring that budget planning is based on actual costs from previous periods, the real expenditure structure and the expected volume of services. Deviations between planned and actual costs should be analysed and used as a basis for improving future budget planning.

Recommendation 2:

Strengthen Primary Healthcare Funding in Line with Its Expanding Responsibilities

Budget planning should ensure that the expansion of primary healthcare functions is accompanied by adequate financial, human, infrastructure and technical resources. Performance assessments should go beyond measuring the number of services delivered and specifically evaluate primary healthcare's capacity to prevent, diagnose and manage chronic diseases.

Recommendation 3:

Ensure Transparency Regarding the Actual Cost of Sterilisation Following the Termination of the Concession

MHSW should publish a comprehensive analysis of the new service delivery model through OSHIS, including initial capitalisation, payments made by hospitals, operating costs, investments, service volumes and unit costs. This information should enable a direct comparison of the cost and performance of the current model with those of the former concession model.

Recommendation 4:

Establish a Unified System for Reporting Service Costs and Performance

For each healthcare output, the source of funding and performance analysis should also be reported in a standardised manner. This would enable a more accurate assessment of expenditure efficiency and reduce discrepancies between physical and financial data.



Recommendation 5:

Make Explanations of Budget Deviations and Underperformance Mandatory

Any significant deviation from financial or physical targets should be accompanied by a clear explanation of its causes, its impact on the achievement of policy objectives, and the corrective measures taken or planned. This is particularly important for new outputs introduced in 2026, for which funding has been allocated but no implementation has been reported during the first four months of the year.



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