



DECENTRALIZATION  
OF REIMBURSABLE PRESCRIPTIONS  
FOR CHRONIC PATIENTS

December 2020

## Background of the insurance scheme and benefit package in Albania

Before 1990 the Albanian health system followed the Russian Semashko model, a centralized system where the Ministry of Health had the policy-making, management, and financing role of the system.

After the change of the political system in 1990, the reform of the health system began, starting with the privatization of dental care and the open network of pharmacies.

In this situation, there was a pressing need to create a financial institution but also to protect the population from out-of-pocket payments on health needs. Under such conditions, the *Law on Health Insurance no. 7870, dated. 13.10.1994* was adopted, and pursuant to the Law, the Health Insurance Institute (HII) was established in March 1995 which started its activity in Tirana and expanded throughout the country within a few months.

Two elements were included in the benefit package for insured persons:

- 1) Payment of salaries for General Family Practitioners (GFP)
- 2) Reimbursement of drugs and medications prescribed in the GFP prescription

After 46 years of the Semashko system implementation in Albania, where the main functions of the health system - policy-making, financing and service delivery - were centralized at the Ministry of Health, roles and stakeholders started separating.

Thus, the ministry as a policymaker continues to cover the financing and management of the hospital sector, while the HII is a new stakeholder that plays the role of collector of contributions and funder of the family medicine service and drug reimbursement in the open network of pharmacies. Albania also saw the emergence of two new stakeholders in health service delivery: the family doctor and the open network of pharmacies.

The Health Insurance Scheme in Albania is currently based on the Bismarckian model, which dates back to late-nineteenth-century Germany when German Chancellor Otto von Bismark first applied the social insurance scheme to the lower classes.

This model is based on the compulsory health insurance contributions by employers and employees, based on a rate regulated by law, retrieved from the salary, and ensures protection of the population from the financial consequences of diseases based on the prepayment of the receivable service, emphasizing the principle of solidarity.

The health contribution rate in Albania is currently 3.4%, where 1.7% is paid by the employee and 1.7% by the employer. Health insurance is compulsory for all persons residing in the Republic of Albania, including foreign citizens employed in Albania.

## What are the source of financial revenues of the health insurance scheme in Albania?

Insured persons are divided into three categories: the economically active, the economically non-active, and voluntary persons, as follows:

### Compulsory health care insurance

1. Compulsory health insurance is based on the contributions of employees, employers, state and other sources for other people, as provided for in this law, based on the principle of solidarity.
2. Compulsory health care insurance scheme intends to cover the population with health care services, financed by the public and private sector, according to this law.

### Insured persons

1. Compulsory health insurance and payment of relevant contributions are mandatory for all economically active persons, with permanent residence in Albania, as:
  - a) employees;
  - b) self-employed except of self-employed pensioners, who receive a pension and who perform professional economic activities on their own, under Article 7, of this law, who have no obligation to pay health insurance contributions;
  - c) unpaid family employees for taxpayers as defined by the Council of Ministers;
  - d) other economically active persons.
2. Compulsory health insurance also covers the following categories of economically non-active persons, whose contributions is financed by the State Budget or other sources as defined by the law:
  - a) persons benefiting from the Social Insurance Institute;
  - b) persons receiving economic aid or payment for disability, in accordance with the relevant legislation;
  - c) persons registered as unemployed-jobseekers in the National Employment Service;
  - d) foreign asylum seekers in the Republic of Albania;
  - e) children under the age of 18
  - f) pupils and students under the age of 25 provided that they do not have income from any economic activity;
  - g) categories of persons defined by special laws.
  - h) victims of trafficking, as identified by the structures of the Ministry of Interior.
3. Persons not included in items 1 and 2 of this article, have the right to voluntarily join the compulsory scheme. Voluntarily insured persons have the same rights and obligations as persons who are subject to compulsory insurance if they meet the condition of the six-month-waiting period from the date of registration and payment of the contribution until the date of their entitlement to benefit.

## The compulsory health insurance service package

1. The compulsory insurance finances the compulsory insurance service packages that include:
  - a. medical check-ups, examinations and treatment in public primary health care centers and public hospitals;
  - b. medical check-ups, examinations and treatments in private primary health care and hospital providers.
  - c. drugs, medical products and treatments by contracted health service providers.

In paragraph c, item 1, Article 10 “Compulsory health insurance service package” defines the drugs part of the benefits package from the compulsory health insurance scheme. Drugs reimbursed from 50% -100% are part of the list of reimbursable drugs (positive list), which is annually approved by a government decision. The revision process of the list of reimbursable drugs has changed over the years, but based on the current regulatory framework, the process is as follows:

2. The compulsory insurance service packages are drafted by defining:
  - a. the list of reimbursable drugs, as well as the extent of coverage. The drug list structure is determined based on the list of essential drugs, according to the INN classification (active pharmaceutical ingredient), defined by the World Health Organization, and coverage of the cheapest option;

The service packages are drafted by technical commissions, composed of experts, who equally represent the division of medical, economic, and social criteria. The nominative composition of the technical commissions is determined by the Administrative Council of the Fund, according to the rules set out in the statute of the Fund.

After the preparation of the list of the reimbursable drugs (RDL) by the technical commissions, the financial invoice of the list is prepared and submitted to the Administrative Council of the Fund which approves the bill, submits it to the Minister of Health for processing at the Council of Ministers. The approval of the LRD submitted by the Minister of Health and accompanied by the financial report of the General Director of the Fund passes by a decision of the Council of Ministers.

After the approval of the LRD, the pathologies for which the drugs will be used and the ways of use are determined, known as the restrictions on the use of drugs. Such restrictions are intended to strike a fair balance between the demand for medication and the financial ability of the scheme to afford the invoice in the absence of medical guidelines and clinical protocols. Setting the drug price, the reimbursable part, and the co-payment part of the patient is also part of the LRD. In the LRD practice, the first drug of the relevant category (e.g. antihypertensives) is covered by

reimbursement to its maximum, while the patient has to pay the price difference for the other options.

Patients with chronic or acute co-morbidities, who need treatment and are insured, are issued a reimbursed prescription. Every doctor (family or specialist doctor) can prescribe up to 3 drugs, except for patients falling under the "veteran" category who are reimbursed for every drug. The patient obtains reimbursed drugs in an open network of pharmacies (private pharmacies) that have signed a contract with CHCIF or in public hospital pharmacies. Open network pharmacies are located in every city of the country and a part of rural areas. There are 850 pharmacies and 58 pharmaceutical agencies (operating in rural areas and run by pharmacists' trainees) that have signed a contract with CHCIF.

The drug marking in the open network of pharmacies or hospitals is based on the decision of the Council of Ministers approving the LRD.

The LRD in force was approved by DCM 77, dated 31.01.2020, indexing LRD 2019, and extending its financial effects on February 1, 2020. In DCM No. 444, dated 26.06.2019 "On the approval of the list of drugs reimbursed by the Compulsory Health Insurance Fund and the amount of coverage of their price", paragraph 1 states:

1. Approval of the list of reimbursable drugs marketed in hospital pharmacies, which are attached to this decision.

### **How are reimbursed drugs obtained by the chronic patients?**

Every patient suffering from a chronic condition shall follow the referral system in order to diagnose and treat it. According to this system, the check-ups, examinations, diagnosis and treatment of the patient in accordance with their health condition is gradually transferred from the family doctor / general practitioner to the specialist doctor in the municipality or region, and for rarer or complicated pathologies, is referred to the University Hospitals.

This movement of the patient in the system is defined in Law no. 10107, dated 30.3.2009, "On health care in the Republic of Albania", as amended, which defines:

1. The citizen's contact with the primary health care service provider or the family doctor is the starting point of the health care service delivery process and takes place on the basis of the referral system to other levels of care.
2. The Minister of Health determines the operation of the patient referral / follow-up system.

Based on this legal framework, Order no. 28, dated 26.01.2016 "On the referral system and public health service fees", of the Minister of Health and Social Protection was issued and it thoroughly

describes how all patients, including chronic patients, can benefit from health care services through the referral system.

According to this order, any citizen who needs to receive services in public health institutions shall first get visited by the family doctor / general practitioner of the Health Center where they are registered.

If the family doctor / general practitioner deems that the diagnosis or treatment of the case requires more specialized consultation, laboratory tests, and other examinations, they shall recommend the patient to the specialty polyclinic in whose jurisdiction the Health Center is located.

The specialist doctor at the specialty polyclinic treats the patient on an outpatient basis or has the patient admitted to the municipal hospital, or refers them for more specialized consultation in the specialty polyclinic of the respective region, equipping them with the relevant referral report.

The patient who is being treated in a municipal hospital and needs diagnoses, examinations, and treatments that are not provided by this hospital, is sent with the accompanying medical report to the regional hospital after the consultation is signed by the treating doctor and the head of the hospital service.

The specialist doctor at the polyclinic of specialties in the region treats the patient on an outpatient basis has the patient admitted to the regional hospital, or refers them for more specialized consultation or treatment to the consulting service of the University Hospitals equipping them with the relevant referral report.

The patient who is treated in a regional hospital and needs more specialized diagnosis, treatment and examination, is sent with the accompanying medical report to the University Hospitals after a consultation signed by the treating doctor and the head of the service. Insured persons benefit from the reimbursed prescription if they only follow the referral system.

As noticed from the referral system, the patient moves from one level of health care to another higher level, based on the needs and their solution by the health institution where patients are referred to. After the patient performs all the necessary diagnostic procedures and a diagnosis is determined, the doctor who determined the diagnosis describes the treatment scheme.

The patient with the defined diagnosis and the treatment scheme meets the family doctor to get the reimbursed prescription if the drugs are found in the open network pharmacies.

If the patient suffers from rare or serious chronic diseases that need treatment by expensive drugs, in order to avoid the 24% margin price increase if they were sold in open network pharmacies, they are sold in public hospital pharmacies.

However, drugs marketed in hospital pharmacies are mostly sold in the University Hospital Center "Mother Teresa" pharmacy, by increasing dramatically the financial burden and social cost of drug purchasing in Tirana for patients from across the country. From a LRD 2020 study, it was noticed that out of 59 drugs (active ingredients), only two can be received in regional hospital pharmacies (Table 1).

Table no.1: Number of active ingredients marketed in hospital pharmacies

	Number of active ingredients marketed in hospital pharmacies	Marketet in UHCT pharmacy	Marketet in regional hospital pharmacies
Antianemics	4	4	0
Pituitary and hypothalamic hormones	2	2	0
Systemic antivirals	9	9	0
Antineoplastics	18	18	0
Endocrine Therapy Drugs	2	2	0
Immunostimulants	2	2	0
Imunosuppressives	12	12	0
Antiparkinsonians	2	2	0
Psycholeptics	2	2	2
Antiasthmatics	1	1	0
Ophthalmic medication	2	2	0
Other therapeutic products	3	3	0
<b>TOTAL</b>	<b>59</b>	<b>59</b>	<b>2</b>

The determination of which pharmacies the drug is marketed in is set out in the “restrictions” column of the LRD. For the drug marketed at UHCT pharmacy the definition is as in Figure 1:

Figure 1: Drugs marketed in UHCT under the LRD 2020 restriction

Kod Bari	Kodi ATC	Principi Aktiv dhe Doza	Forma	Emri Tregëtar	Mbajtësi i Autorizimit për Tregëtim	Çmimi Referencë	Çmimi i Pacientit	Rimbursimi	Kufizimet
<b>B</b>									
<b>B03</b>									
<b>GJAKU DHE ORGANET E HEMOPOJEZES</b>									
<b>ANTIANEMIKET</b>									
55/237	B03XA01	Epoetin Alfa 2000 Nj.N	pre-filled syringe	Binoort	SANDOZ	916.48	45.83	870.65	Në Anemi sekundare nga IRK, dializë. Me konsultë dhe nën monitorimin e përgjegjësitë e mjekut të QDUT.
346/41	B03XA01	Epoetin Beta 2000 Nj. N	pre-filled syringe	Recormon	ROCHE	1,086.68	54.33	1,032.35	Në Anemi sekundare nga IRK, dializë. Me konsultë dhe nën monitorimin e përgjegjësitë e mjekut të QDUT.

As for the drugs marketed in the pharmacies of regional hospitals, the column "restrictions" sets out *under the referral of the specialist doctor from the regional hospital where it is marketed*:

Figure 2: Drugs that are also marketed in regional hospitals

N05 PSIKOLEPTIKËT									
593/194	N05AX08	Risperidone 25mg	tret.per inj.	Risperdal Consta	JANSSEN - CILAG	8,828.30	1,765.66	7,062.64	Me konsultë dhe nën përzgjedhje të mjekut të shërbimit të Psikiatrisë në GGUT të mjekëve psikiatër të spitalëve rajonale ku tregëtohet ky bar.
594/194	N05AX08	Risperidone 37.5mg	tret.per inj.	Risperdal Consta	JANSSEN - CILAG	12,490.20	2,498.06	9,992.14	Me konsultë dhe nën përzgjedhje të mjekut të shërbimit të Psikiatrisë në GGUT të mjekëve psikiatër të spitalëve rajonale ku tregëtohet ky bar.
595/194	N05AX08	Risperidone 50mg	tret.per inj.	Risperdal Consta	JANSSEN - CILAG	15,031.56	3,006.32	12,025.24	Me konsultë dhe nën përzgjedhje të mjekut të shërbimit të Psikiatrisë në GGUT të mjekëve psikiatër të spitalëve rajonale ku tregëtohet ky bar.

In the “restrictions” column for the drug prescription, and the level of the pharmacy where the drug is obtained, it is noticed that everything depends on the presence of the respective specialist, and there is also a certain “monopoly” of prescribing expensive drugs by UHCT specialists.

On the other hand, it is the relevant UHCT services (hematology or endocrinology) that prepare the protocol of use of the drug, through which they maintain this "monopoly". Monitoring the clinical progress of patients with chronic diseases at the level of municipal or regional hospitals becomes impossible for certain diagnoses due to the lack of not only laboratory infrastructure or relevant specialists, but mostly due to the lack of clinical protocols for relevant diseases.

The first and last time that guidelines and treatment protocols were approved, was in 2010, when NCQSA led the process of preparing clinical guidelines and protocols, which were approved by order of the former Minister of Health, Petrit Vasili.

## What are the costs for chronic patients with low physical access to medication?

Chronic patients from all over the country receive the necessary drugs for the treatment of their pathologies only at UHCT in Tirana, which has multidimensional costs for these patients and their families. The cumulative costs for all patients who are visited, treated, monitored, and receive medication at UHCT, is very large given the pathologies and the number of patients for each pathology. There are a large number of pathologies with centralized service in UHCT, as below:

Table no.2: List of pathologies treated at UHCT

	Group	Complication	Disease	Drug	Health care level	Check-up frequency
1	Antianemics	Secondary anemia	Chronic kidney insufficiency, Dialysis	Epoetin	Hematologist, UHCT	
2	Pituitary and hypothalamic hormones	Growth hormone deficiency; Growth retardation in height of idiopathic nature; Young children of childbearing age;	Turner Syndrome; Specific genetic syndrome; Chronic kidney insufficiency	Somatropin	Pediatric endocrinologist, UHCT	Every 3 monthss
3			Acromegaly	Octreotide	Endocrinologist, Oncologist, UHCT	
4	Systemic antivirals	Cytomegalovirus infection	Transplant;	Valganciclovir Hydrochloride	Specialist, UHCT	
5		Chronic hepatitis; Hepatic cirrhosis		Tenofovir	Gastro-hepatologist, UHCT	
6		Liver fibrosis, stage F3-F4	Hepatitis C	Sofosbuvir +Velpatasvir	Gastro-hepatologist service commission, UHCT	
7				Glecaprevir +Pibprentasvir		
8				Sofosbuvir		
9				Dasabuvir		
10				Ledipasvir +Sofosbuvir		
11				Ombitasvir +Paritaprevir +Ritonavir		
12	Elbasvir +Gazoprevir					
13	Antineoplastics	Metastasis	Head tumors	Lomustin	Consultation at Neurosurgery service, UHCT	
14			Multiform glioblastoma	Temozolomide	Consultation and monitoring at Neurosurgery service, UHCT	

15		Metastasis	Breast cancer; Gastrointestinal tract cancer	Capecitabin	Consultation and monitoring at Oncology service, UHCT		
16			Non-Hodgkin lymphoma	Rituximab	Consultation at Hematology/Oncology service UHCT		
17			Only in Breast cancer	Trastuzumab	Consultation Oncology service, UHCT		
18			Inoperable melanomas	Pembroluzimab	Consultation Oncology service, UHCT		
19			Only in first-line tumor	Sunitib	Consultation Oncology service, UHCT		
20			Advanced hepatocarcinoma; Thyroid carcinoma	Sorafenib	Consultation Oncology and Endocrinology services, UHCT		
21			Chronic Myeloid Leukemia	Nilotinib	Consultation and under the monitoring and responsibility of the Hematology service, UHCT	Every month to assess peripheral blood. Every 3 months: liver, kidney and heart functions	
22			In non-first-line tumor	Pazopanib	Consultation and monitoring at Oncology service, UHCT		
23			Presence of BRAF V600 mutation	Inoperable melanomas	Vemurofenib	Consultation and monitoring at Oncology service, UHCT	
24				Myelofibrosis	Ruxolitinib	Consultation and monitoring at Hematology service, UHCT	
25			Presence of BRAF V600 mutation	Inoperable melanoma	Dabrafenib	Consultation and monitoring at Oncology service, UHCT	
26				Chronic lymphocytic leukemia	Ibrutinib	Consultation and monitoring at Hematology service, UHCT	
27			Metastasis, positive receptor	Breast cancer	Palbociclib	Consultation and monitoring at Oncology service, UHCT	
28			Metastasis, positive receptor	Breast cancer	Ricoclibib	Consultation and monitoring at Oncology service, UHCT	
29				Chronic myeloid leukemia; GIST	Imatinib	Consultation and monitoring at Hematology and Oncology service, UHCT	
30		Endocrine Therapy		Precocious puberty	Triptorelin	Consultation at Pediatric Endocrinology service, UHCT	
31				Carcinomas with prostate metastasis	Abiraterone	Consultation and monitoring at Oncology service, UHCT	
32		Immunostimulants		Hepatitis B and C; HIV / AIDS	Peginterferon	Consultation at Gastro-hepatology and Infectious Diseases service, UHCT	
33				Multiple sclerosis	Interferon Beta	Consultation at Neurology, Neuropediatrics, UHCT	
34		Immunosuppressives		Post transplant; Chronic resistant glomerulonephritis	Mycophenolate	Consultation at UHCT	
35				Post-transplant conditions; In cases resistant to treatment from other immunosuppressants	Everolimus	Consultation at UHCT	

36			Multiple Sclerosis; Resistant to Interferon	Fingolimod	Consultation and responsibility of the Neurology service doctor, UHCT	
37			Severe Rheumatoid Arthritis	Tofacitinab	Consultation and responsibility of the Neurology service doctor Rheumatology, UHCT	
38			Dermatology: Psoriatic Arthritis, Plaque Psoriasis, Rheumatology: Rheumatoid Arthritis, Ankylosing Spondylitis	Etanercept	Rheumatology and Dermatology service Commission, UHCT	Every 8 weeks (2 months) blood, urine and liver function monitoring
39			Rheumatoid arthritis, Inflammatory bowel diseases,	Infliximab	Rheumatology, Dermatology, Gastro-hepatology service Commission, UHCT	
40			Rheumatoid arthritis, Inflammatory bowel diseases, Psoriasis Vulgaris	Adalimumab	Rheumatology/ Dermatology/ Gastro-hepatology/ General pediatrics service Commission, UHCT	Every 8 weeks (2 months) blood, urine and liver function monitoring
41			Rheumatoid arthritis, Juvenile idiopathic arthritis,	Golimumab	Rheumatology /General pediatrics service Commission, UHCT	Every 8 weeks (2 months) blood, urine and liver function monitoring
42			Arthritis Rheumatoid, Juvenile arthritis rheumatoid	Tocilizumab	Rheumatology /General pediatrics service Commission, UHCT	Every 8 weeks (2 months) blood, urine and liver function monitoring
43			Post-transplant condition; Medullary aplasia; Myelodysplasia; Chronic resistant glomerulonephritis	Ciclosporin	Consultation UHCT	
44			Post-transplant conditions	Tacrolimus	Consultation UHCT	
45		Antiparkin sonians			Levodopa + carbidopa	Consultation at Neurology service, UHCT
46			Parkinson disease when not controlled by other drugs	Apomorphin hydrochloride	Consultation and responsibility of the neurologist, Neurology service, UHCT	
47	Psycholeptics		Schizophrenia and psychotic disorders	Risperidone	Consultation at Psychiatric service, UHCT/a psychiatrist at the regional hospital where it is marketed	
48			Resistant schizophrenia	Paliperidone	Consultation at Psychiatric service, UHCT/a psychiatrist at the regional hospital where it is marketed	
49	Antiasthmatic s		Severe asthma	Omalizumab	Consultation and monitoring at Allergology service, UHCT	

50	Ophthalmic medication		Diabetic macular edema	Ranizimumab	Consultation and responsibility of Ophthalmology service, UHCT	1 year medication
51			Macular edema; Macular neovascular degeneration	Aflibercet	Consultation and responsibility of Ophthalmology service, UHCT	
52	Other therapeutic products		Thalassemia, Sickle cell disease, Myelodysplasia	Deferiprone	Consultation at UHCT (hematology)	
53			Transfusional hemosiderosis; Hemodialysis at terminal stage with severe anemia;	Deferasirox	Consultation at UHCT (Oncology-pediatric hematology; Nephrology)	Monitoring of Ferritinemia, Creatinemia, transaminase
54			Hyperphosphatemia in 4-5 stage chronic kidney diseases	Sevelamer Carbonate	Consultation at Nephrology - hemodialysis service, UHCT	Monitoring of phosphorus every 2-4 weeks,
55			Chronic kidney diseases	Ketosteril	Consultation at Nephrology service, UHCT	

\*Source: Source: List of reimbursable drugs 2020; drug use protocols, CHCIF 2020

According to the table above, the pathologies that are not only diagnosed and prescribed treatment to, but also monitored at the UHCT level, are as follows:

- chronic kidney insufficiency,
- patients on dialysis,
- lack of growth hormone,
- chronic hepatitis,
- hepatic cirrhosis,
- tumors (head, breast, gastrointestinal tract),
- chronic myeloid leukemia,
- melanoma,
- prostate cancer,
- hepatitis B and C,
- HIV / AIDS,
- multiple sclerosis,
- post-transplant conditions,
- rheumatoid arthritis,
- psoriatic arthritis,
- inflammatory bowel diseases,
- juvenile rheumatoid arthritis,
- Parkinson disease,
- schizophrenia,
- psychotic disorders,
- severe asthma,

- diabetic macular edema,
- thalassemia,
- sickle cell disease,
- myelodysplasia,
- hemodialysis

These pathologies, which are of different levels of severity, ranging from the life-threatening ones (tumors) to the ones leading to temporary disability or permanent disability (dialysis), are a heavy health, social and economic burden for the patient. and their family, which is further aggravated by the administrative requirements set for centralized care.

For example, the treatment of Chronic Myeloid Leukemia by Nilotinib is arranged in consultation with the Hematology service at UHCT. Not only the treatment but also the monitoring of the patient's condition is arranged under the monitoring and responsibility of the Hematology service which, together with the requirements for periodic monthly or quarterly evaluation of functional parameters, inflicts a heavy burden on the patient (table 3).

Table No.3: Restrictions on taking Nilotinib

Chronic Myeloid Leukemia	Nilotinib	Consultation and undet the monitoring and responsibility of the Hematology Service, UHCT	Monthly evaluation of peripheral blood. Quarterly evaluation of liver, kidney, and heart functions
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\*Source: List of reimbursable drugs 2020; drug use protocols, CHCIF 2020

The same approach applies to drugs taken for diseases that seriously affect the quality of life and its longevity, such as. HIV / AIDS. The table below shows the restriction for Peginterferon, which is given only by the Infectious Diseases Service at UHCT and is taken only at the UHCT pharmacy (Table 4).

Table 4: Restrictions on Peginterferon for HIV / AIDS patients

Hepatitis B and C; HIV/AIDS	Peginterferon	Gastro-Hepatology and Infectious Diseases Service Consultation, UHCT
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\* Source: List of reimbursable drugs 2020; drug use protocols, CHCIF 2020

HIV / AIDS patients coming from the districts, but also those in Tirana, experienced limited access to the service they needed due to mobility restrictions during the lockdown. On the other hand, the restriction or reduction of access to health care was because the Infectious Diseases Hospital turned to a Covid hospital, which shut down any hospital treatment for HIV / AIDS patients.

The impossibility of hospitalization and treatment led to life losses, such as the case of patient I.Zh. who needed hospital treatment but was not admitted because HIV / AIDS patients could only be admitted to the Infectious Diseases Hospital. Strong interventions were needed for the patient

to be admitted to the hematology ward by the end of September to be under medical observation, but he lost his life after a few weeks.

For many patients, the outbreak situation and the centralization of health services had existential consequences for their lives. Failure to receive timely and regular treatment led to the aggravation of the health conditions, which made all efforts to improve or stabilize their health situation futile. Failure to receive timely treatment and related services, aggravating the health condition, severely affected their quality of life, made them lose their ability to work and generate income for the family. On the other hand, the deterioration of the patient's quality of life imposes a financial burden for their families, because someone needs to take care of them, which limits their daily economic and personal activities.

During Covid-19 pandemic patients suffering from thalassemia felt scared, especially in the period of restricted movement where the intercity movement was banned.

The representative of the Thalassemia Association states that thalassemia patients have faced numerous challenges during the pandemic. They had to travel to Tirana 3 times a month to receive blood. Taxi fees (5000 ALL) were unaffordable for families and thalassemia patients. Many of these patients claim that they could not afford to come to Tirana 3 times a month and left their children without blood.

*In event of a second lockdown where blood transfusion is not possible in their cities, these patients' health is seriously endangered,* said the representative of the Thalassemia Association.

The same situation occurs for dialysis patients, who undergo the hemodialysis procedure three times a week. Now that hemodialysis is performed in Tirana and in four other areas, testing and prescription of medication should be performed by the relevant doctors who are monitoring the patients during hemodialysis sessions, based on the protocol of drug use (table 5) .

Table 5: Limitations of Deferasirox (dialysis)

Transfusion hemosiderosis; Terminal stage hemodialysis with severe anemia	Deferasirox	Consultation at UHCT (Pediatric Oncohematology; Nephrology)	Monitoring Ferritinemia, Creatinemia, transaminases
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\* Source: List of reimbursable drugs 2020; drug use protocols, CHCIF 2020

The financial costs that have to be borne by people with diseases treated at UHCT or their families are significant. Table 6 below shows an example of the financial cost of UHCT monitoring for a patient who lives 200 km away from Tirana, is escorted by a family member, who should stay at a hotel. The cost goes to 18,865.42 ALL and accounts for 35% of the average monthly salary of 54,149 ALL.

Table no.6: Direct financial cost of treatment at UHCT

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	ALL	Day/ALL	Days spent for treatment	Missed profit in ALL (patient + family member)	Daily expenses	
Average monthly salary	54149	2256.2	2	9024.83		
Minimum wage	26000	1083.3	2	4333.3		
Average monthly consumption expenditures of Albanian households	82235	2741.2	2		1370.6	
Average monthly income per capita / equivalent	26144	1089.3	2	4357.3		
Accommodation expenses		4000.0	1			
<b>TOTAL</b>					<b>18865.42</b>	
Transport costs	ALL/liter	Consumption/100 Km	Cost/100 km	25%	Total for 100 km	400 Km
Oil costs	149	6	894			
Depreciation				223.5	1117.5	4470

\*\*Source: INSTAT 2020

## Conclusion

Drugs for the treatment of patients with chronic diseases are part of the health insurance benefit packages since Albania has a Bismarckian (mixed) funding system based on the compulsory health insurance scheme for the health services prepayment. Access to these drugs, i.e. the type of reimbursable drugs and the pharmacies where these drugs are purchased, are regulated by relevant administrative acts.

Depending on their pathology, severity, and frequency of the disease, chronic patients have to go through a long way to the final diagnosis through the referral system. For many of the severe or rare pathologies, patients find solutions for their diagnosis and treatment only at UHCT Tirana.

In the vast majority of chronic pathologies (HTA, diabetes, etc.) drugs are received in the open network pharmacies located in every city or even in many administrative unit centers in rural areas.

However, for severe and rare chronic diseases, which have serious health consequences, patients face limited physical access to drugs and have to travel to Tirana for the next treatment.

This reduced physical access has a significant social and financial cost for patients and their families, as they have to travel, be accommodated, and purchase the drugs when they are not 100% reimbursable.

Decreased access to health services, but also to the purchase of the necessary drugs, is associated with the lack of diagnostic infrastructure of relevant specialists, and clinical guidelines and protocols for the relevant pathologies.

On the other hand, there is a "monopoly" on certain services and drug descriptions by the relevant UHCT services, which are sanctioned through drug use protocols (in the absence of guidelines and clinical protocols).

Every hospital in the country has a hospital pharmacy, which should enable increased patients' access to hospital drugs as close as possible to their place of residence.

This is made possible by the presence of national registers of chronic patients by pathologies, which limits any chances of abuse of reimbursed prescriptions.

## Recommendations:

In order to increase the access of chronic patients receiving medication in hospital pharmacies, it is recommended that:

- Good practice with diabetic patients in the use of telemedicine for counseling and therapy be applied. Telemedicine platforms for consultation between the regional hospital specialists and UHCT specialists can be organized for periodic assessment of the patients' conditions and treatment schemes. Tests that can be performed at regional hospitals should be performed to reduce the social and financial costs of the patients and their families.
- Good practice be applied with hemophilia patients during the lockdown due to the Covid-19 pandemic, based on the CHCIF decision, dated 22.03.2020, "Clarification on the treatment of chronically ill patients who receive reimbursable drugs marketed in hospital pharmacies". Regional hospitals should provide treatment to chronic patients who receive reimbursable drugs sold in hospital pharmacies.
- The reimbursable prescriptions from relevant UHCT or regional hospital specialists be prescribed via e-prescription, and executed at any municipal or regional hospital pharmacy. It is also possible to arrange the payment modalities of the patient's co-payment through bank transfers.
- The period for which the treatment is given be reviewed based on the pathology and the relevant guidelines, where possible. For pathologies that have a long course and the parameters do not change quickly, medication can be prescribed for 3 months, in order to reduce the financial cost for patients or their families.
- Tripartite contracts are signed between CHCIF - municipal hospital - distributor in order to supply them with reimbursable drugs that are distributed in hospital pharmacies.
- Guidelines and clinical protocols are prepared. That would facilitate the treatment and prescription of relevant drugs, depending on the severity of the disease by relevant specialists in regional hospitals, after the final diagnosis and registration of the patient in the national register of the relevant pathology.